

December 2011

ANZCA BULLETIN



FPM
FACULTY OF PAIN MEDICINE
ANZCA

Pain and anaesthesia
research grants:
ANZCA announces
the successful projects
for next year

PLUS:
LOGBOOKS FOR TRAINEES
AND THEIR KEY ROLE IN ANZCA
CURRICULUM REVISION 2013





20 Spirit of anaesthesia

Dr David Fenwick is enjoying life after anaesthesia.



ANZCA Bulletin

The Australian and New Zealand College of Anaesthetists (ANZCA) is the professional medical body in Australia and New Zealand that conducts education, training and continuing professional development of anaesthetists and pain medicine specialists. ANZCA comprises more than 4500 Fellows across Australia and New Zealand and serves the community by upholding the highest standards of patient safety.

Medical editor: Dr Michelle Mulligan

Editor: Clea Hincks

Sub editors: Meaghan Shaw and Kylie Miller

Production editor: Liane Reynolds

Design: Christian Langstone

Advertising manager: Mardi Peters

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Contacts

Head office

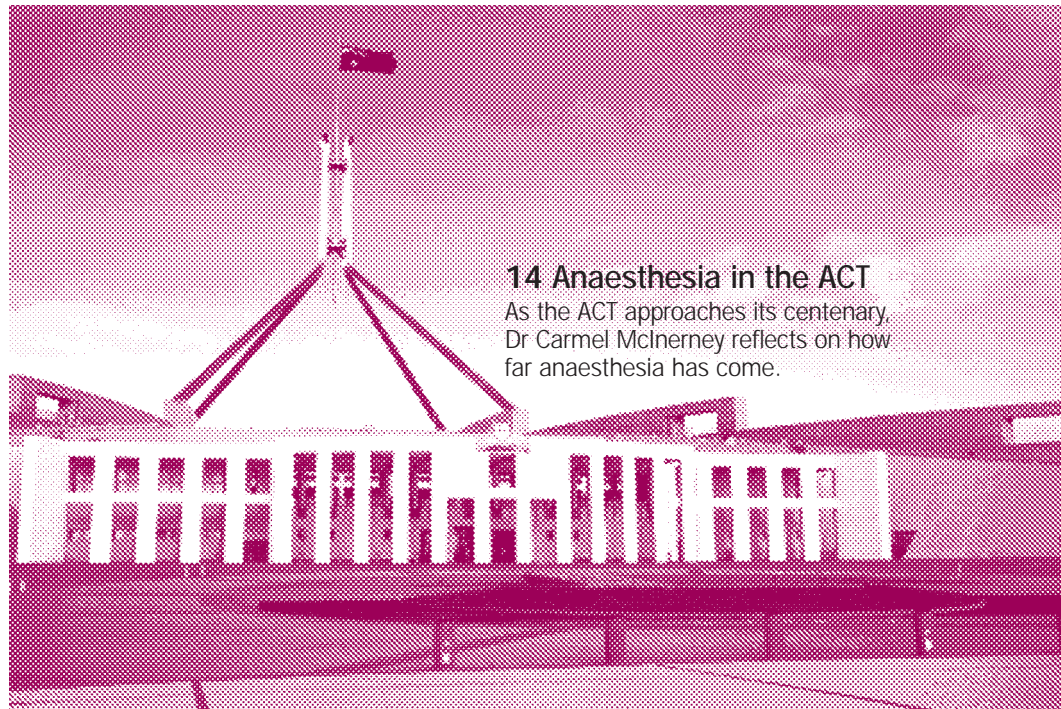
630 St Kilda Road, Melbourne
Victoria 3004, Australia
Telephone +61 3 9510 6299
Facsimile +61 3 9510 6786
communication@anzca.edu.au
www.anzca.edu.au

Faculty of Pain Medicine

Telephone +61 3 8517 5337
painmed@anzca.edu.au

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Cover: "The spirit of anaesthesia"
sculpture by Dr David Fenwick.



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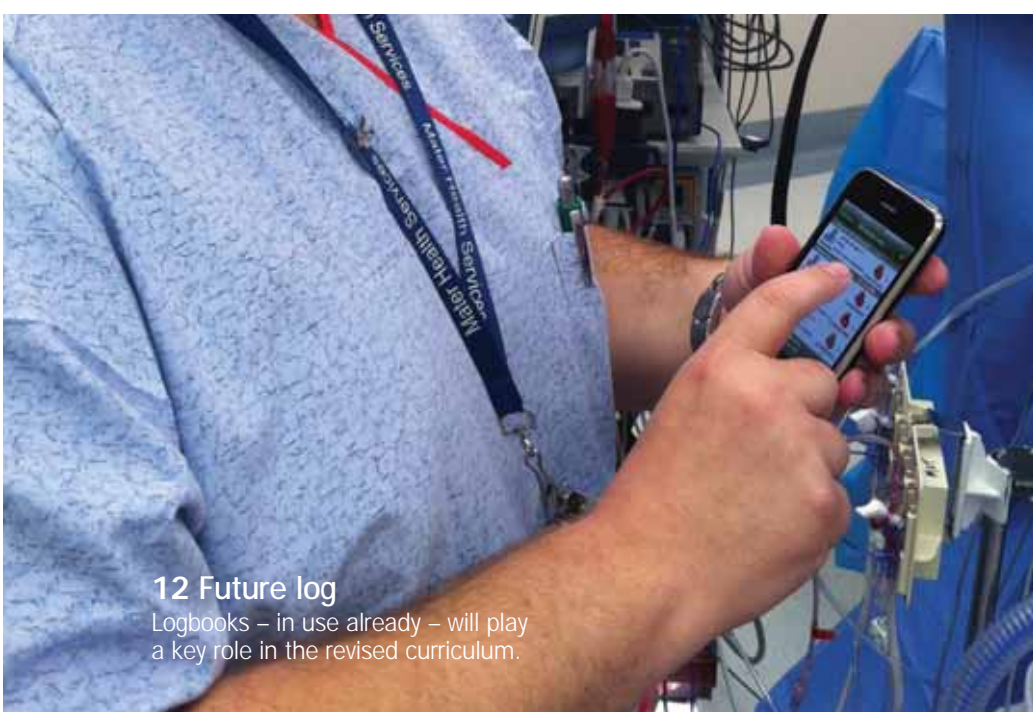
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President's message



Welcome to the December 2011 *ANZCA Bulletin*. It's timely once again to reflect on what our College has achieved this year and what our vision is for 2012.

None of these achievements would have been possible without the fabulous contributions of so many Fellows and trainees and, of course, our dedicated staff, led by our CEO, Linda Sorrell, and Deputy CEO, Carolyn Handley. I would like to thank everyone who has contributed for their hard work and enthusiasm. This year we have:

- Held a wonderful combined scientific meeting in Hong Kong that attracted 1630 delegates.
- Launched the redesigned ANZCA website with enhanced navigability, new patient information and improved content.
- Reviewed our Continuing Professional Development (CPD) program to provide a better, more robust system for participants with a redesigned and more intuitive website.
- Commenced development of an online GP pain management education program (a joint project between the Faculty of Pain Medicine and the Royal Australian College of General Practitioners funded by a \$200,000 grant).
- Made great progress with ANZCA Curriculum Revision 2013, including detailed plans for the supporting IT system and communications package.
- Developed and delivered more e-learning resources with the commencement of a pilot for the online teacher course and an increased number of podcasts developed for trainees.
- Improved our communications with trainees and their supervisors, including the introduction of a new *Training E-Newsletter*.

- Achieved widespread media coverage and publicity through more than 25 media releases and direct dealings with the media.
- Prepared more than 50 policy submissions and responses to government departments, agencies and regulatory bodies in Australia and New Zealand.
- Completed a New Zealand workforce study and commenced a focused advocacy program for our specialty in New Zealand.
- Funded medical research grants to the tune of \$861,000 and reinvigorated our Anaesthesia and Pain Medicine Foundation.

Our vision for 2012 – three key areas of engagement

Our trainees

ANZCA is designing a state-of-the-art anaesthesia curriculum for implementation in the 2013 hospital year, which will ensure that ANZCA continues to produce specialists of the highest calibre and remains at the forefront of specialist medical colleges worldwide. Next year is the major year for capital investment in the project and the development of the online trainee portfolio and logbook.

A major project is also in place to communicate these changes to trainees and their supervisors, and up-skill them in workplace-based assessment. The Australian Medical Council and Medical Council of New Zealand will assess the redesigned curriculum later in 2012, with a major project under way to complete our accreditation submission.

In another exciting development for 2012, ANZCA has secured a grant from the Australian Department of Health and Ageing of substantial funding over two years for the Specialist Training Program (STP) for anaesthetic, pain medicine and College of Intensive

Care Medicine (Australia and New Zealand) trainees. The STP provides federally funded training posts in private hospitals, rural centres and other diverse environments. The bulk of the funds will be transferred to training sites that have successfully secured training posts. Funds also have been provided to ANZCA to manage the contracts, provide e-learning and teacher training initiatives and support international medical graduate specialists. Our staff will be able to support further applications for STP posts for 2013 and beyond.

Our Fellows

The final actions from our 2010 Fellowship Survey are being completed in 2012, with the aim for meeting our commitment to improve services to Fellows and engagement of Fellows with their College.

Key items in this program include continued refinement and improvement of our website during 2012, improved CPD program accessibility with capital expenditure earmarked in 2012 to provide access to the program from mobile devices, continued improvement of the systems underpinning our CPD, including assistance to participants having difficulty meeting requirements, and increased regional office capability.

The budget for 2012 has flagged increased staff support in South Australia and Western Australia, and relocation of the South Australian office to larger, more suitable premises as priorities. This follows increased support in other regions, including New Zealand and Tasmania, this year.

I am grateful for the work that our Fellows do in the regions to support training and CPD; with the growth of our specialty your role will increase and is highly valued.



Our neighbours

Can you imagine caring for your patients under anaesthesia without the comforting “beep-beep” of a pulse oximeter?

Pulse oximetry has been in routine use in New Zealand and Australia since the 1980s and is mandated for all our patients by the College’s professional document *PS18 Recommendations on Monitoring during Anaesthesia*. Yet in some of our near-neighbour countries, pulse oximeters are hard to come by and lives are lost as a result.

Lifebox was founded by the World Federation of Societies of Anaesthesiologists (WFSA), the Association of Anaesthetists of Great Britain and Ireland, the Harvard School of Public Health and the Brigham and Women’s Hospital and aims to bridge the “pulse oximetry gap” – currently estimated at 77,000 devices worldwide.

The President of WFSA, Dr Angela Enright, highlighted the project during her recent visit to Auckland for the New Zealand ASM (a combined meeting of the ANZCA New Zealand National Committee and the New Zealand Society of Anaesthetists). Dr Enright emphasised that a donation of only \$US250 will secure a pulse oximeter that may change the lives of many patients in a low-income nation.

ANZCA has a long-standing and much-cherished relationship with our near neighbour, Papua New Guinea, where we contribute every year to the education of anaesthetists and anaesthetic scientific officers, and the continuing professional development of Fellows, through the International Scholarship (valued at \$56,000), Essential Pain Management course and other projects.

In 2012, the College will be making an additional contribution to Papua New Guinea through a \$10,000 donation to Lifebox, enough for 40 new pulse oximeters. As Professor Alan Merry, ANZCA councillor and Chair of the Quality and Safety of Practice Committee of the WFSA, commented in the September edition of the *ANZCA Bulletin*: “There’s real momentum already under way. This is a real chance to get involved, make a difference and save lives through safer surgery.”

I therefore encourage all Fellows and trainees to visit the Lifebox website (www.lifebox.org), watch the heart-rending but inspiring video (turn the music up loud), share what you have learnt with colleagues, family and friends, and consider making a donation to Lifebox or giving a donation instead of a gift over the holiday season. Your contribution will make a real difference.

In closing, I would like to thank everyone who has contributed to another successful year at the College and wish everyone a safe and joyous end to the year and a happy new year!

Professor Kate Leslie
ANZCA President

Letters to the editor



Re: Is there a doctor on board? (September 2011)

The interesting article on in-flight emergency simulation training at the recent Hong Kong CSM prompts me to relay an incident that happened only a month later and describes what happens in the real world.

Halfway through a flight from Fiji, returning from an ophthalmic surgical outreach program, there was a call over the public address system of the full Boeing 747 for a doctor. The four ophthalmologists I had been working with simultaneously pointed at me and firmly retained their seats. I made myself known to the cabin staff and was ushered to the rear of the plane where a man was lying stretched out in the very narrow corridor which connects the two rear toilets.

A brief history taken from his wife revealed that he was a man in his mid-50s with multiple co-morbidities including cirrhosis, liver failure, liver cancer and a previous stroke. He had been on holiday in Fiji but had been unwell for the past few days, suffering abdominal pain, nausea and vomiting. He had been unable to keep any food or fluid down.

Examination was difficult but he was patently very unwell. He looked pale, had a rapid thready pulse and his systolic blood pressure by palpation, (there was no stethoscope) was 80mm.Hg. I concluded that he had collapsed as a result of hypotension secondary to dehydration.

The emergency medical kit was produced and, although somewhat old and dusty, I did find a litre of Hartmann's solution and a giving set.

I managed to cannulate a vein, although there was no tape available and we had to secure it with Band-Aids. His condition improved somewhat with the fluid and when the captain called to ask if he needed to divert the plane I informed him that this would not be necessary. However, I requested that an ambulance be ready at the arrival of the plane and that a stretcher be waiting as soon as we disembarked as I considered that he needed urgent hospital care. I was assured that this would be done.

On arrival in Sydney all the passengers were let off before us but when I got to the door I found that there was neither stretcher nor any thought of one. Finally an airport employee arrived with a wheelchair and all we could do was bundle the patient into this. No one in sight was aware of a medical emergency, nor seemed to care much. We wheeled the patient to passport control where we did get some priority in the queue but then had to wait for bags to be collected before he was finally wheeled out to the concourse where I expected the ambulance to be waiting. No one knew anything about it and the patient, his wife and myself were dumped rather unceremoniously in the cold and draughty arrivals hall. I inquired about the medical centre at the airport but it was midday on a Saturday and it was closed.

Finally, in desperation, I phoned 000 and spoke to the NSW ambulance who said no call or arrangement had been made. Nonetheless they sent an ambulance and three quarters of an hour later the patient was finally on his way to hospital.

Aviation is often held up to we anaesthetists as model of practice but in this instance a serious breakdown of communication between the air and the ground led to sub-optimal care of this patient.

Dr Terry Clarke

Director, Department of Anaesthetics and Pain Management
Nepean Hospital, Penrith, NSW



Re: NZ anaesthetic technicians can now register as health professionals (September 2011)

I was delighted to read the article by Susan Ewart, describing the “11-year process” that has resulted in anaesthetic technicians in New Zealand now being able to register under the Health Practitioners Competence Assurance Act. I congratulate all those involved in achieving this important professional goal for our operating room colleagues. Throughout my anaesthetic career, I valued highly the support of the many fine men and women who have worked alongside me in this capacity.

However, the process of developing the professional role of anaesthetic technicians to where it is today is, in fact, much longer than the 11 years since the NZ Anaesthetics Technicians Society expressed “their wish to be covered by this legislation”. The first anaesthetic technicians training course in New Zealand was developed by myself in 1978, 33 years ago, soon after I arrived in Christchurch as a full-time specialist for the then North Canterbury Hospital Board. In order to complete the early history of technician training in NZ, it is worth quoting from a 1990 Department of Anaesthesia internal publication that covered the history of anaesthesia in Christchurch from 1974 to 1990.¹

As far as I know, at least two of those original five graduates were still working as anaesthetic technicians in Christchurch until very recently.

Associate Professor (retired) Michael Davis, MB, BChir, MA (Cantab.), FRCA(Eng.), FANZCA, MD(Otago), DipDHM, CertDHM(ANZCA) Christchurch

Reference

1. Davis FM, editor. *Department of Anaesthesia 1974–1990. The changing face of anaesthesia in the public health system.* Christchurch: Canterbury Area Health Board; 1990.



Re: Welfare Issues: Helping doctors in need (September 2011)

Dr Di Khursandi and the Welfare SIG are to be commended for highlighting the extraordinary high suicide rate in our profession. The obituary column in this journal over the last year individualises this tragic situation, with many of us being friends or colleagues of the deceased. In my career spanning 30 years and three countries, I have experienced the loss of seven anaesthetists from suicide, with whom I have shared theatres and a place in the life of the departments. Dr Khursandi quotes that suicide is the cause of death in up to 10 per cent of anaesthetists. I cannot find another profession that has this incidence and, indeed, death related to an occupation. Even professional soldiers have a lower rate.

Were we any other group this incidence would place us in the category of a public health emergency. The Australian national average for death from suicide is 1.5 per cent. New Zealand has a similar level. High risk groups, for example, young men in indigenous communities, living in remote

Welfare SIG responds

I welcome Dr Lewer's personal and insightful reflections. He notes the paucity of Australasian research into anaesthetists' suicide rates and I welcome his suggestion for collaboration with experts in this field. I am aware of only one multidisciplinary research group currently investigating suicide among anaesthetists in Australia¹.

Very few studies have been done to determine cause of death in anaesthetists. What we know is that depression and suicide figure prominently in American and European studies^{2,3}. Research has not previously been the focus of Welfare SIG activities, but we are keen to encourage and communicate with Fellows and trainees interested in, or researching, anaesthetists' mental health and morbidity.

The Welfare SIG fosters awareness and promotes education in many arenas. In 2011 revised resource documents

regions, have a rate approaching 6 per cent⁴. The actual rate of suicide may well be higher as many are not listed as such in coronial reports or death certificates¹.

It is untenable that we have not previously highlighted this issue and encouraged research on this crisis. The Australian Institute for Suicide Research and Prevention (AISRAP) associated with Griffith University, is undertaking a three-year study to address the causes of suicide in farmers who have an incidence of around 3 per cent. Of crucial interest is their aim to examine occupation as a factor in suicide separate to mental illness.

Surely we warrant a similar study? In the meantime we as a profession can take measures to address this situation. Low self-esteem remains a critical factor. In my experience, we could learn from those of our surgical colleagues who are largely capable of dismissing adverse events and occasional disastrous outcomes through a realisation that other surgeons would likely have done no better under the circumstances. Perhaps we have been too critical of our trainees' performance and did not instill this belief?

We need to continue to raise the profile and understanding of anaesthesia in our work places and outside. It is a sad reflection on communication between specialists that even after having worked with a particular anaesthetist for many years, a number of surgeons still have very little insight into what he or she actually does. It is often also true to say the same about the insight our close family members have into our occupation.

addressed topics Dr Lewer has touched upon, including *RD 03 Depression and Anxiety*, *RD 05 Critical Incident Support* and *RD11 After a Major Mishap*.

Like all SIGs our activities involve volunteers. For example, all executive members contributed to the writing/revision of the resource documents.

SIG members are involved in welfare-oriented sessions at scientific meetings ranging from regional trainee-run meetings to national meetings. Many individuals are making substantial contributions to their regions also – the South Australian trainee welfare initiative being an outstanding example.

All anaesthetists may be called upon to advise colleagues in difficulty. The *RD 13 Impairment in a Colleague* raises an important issue – not to take on a duty of care, but rather to assist with accessing professional help and resources, such as the Doctors' Health Advisory Service.

I do have concerns that through promoting anaesthesia as very safe we have exposed ourselves to danger. I recently counted 26 drugs in the top drawer of my anaesthesia trolley that, if inappropriately administered, could result in death. Anaesthesia per se is dangerous, but with appropriate training, skills and experience the anaesthetist delivers good outcomes.

I have stopped using the analogy that driving a car is a similar risk to having anaesthesia. I would happily be driven by a 16 year old who has had five lessons. For the same level of confidence prior to anaesthesia, I would want my anaesthetist to have a great deal more.

Providing informed consent and discussing the possibility of bad outcomes has been a significant advance over the last decade, in that it highlights the risks involved for both the patient and ourselves. It also dispels the myth that anaesthesia is risk free.

Dr Brian Lewer, FANZCA
Sunshine Coast, Queensland

Reference

1. Breaking the Silence: Suicide and Suicide Prevention; a Seminal Report: Lifeline Australia and Suicide Prevention Australia 2010.

We are not experts in suicide prevention. By openly encouraging our colleagues to seek professional care we may gradually erode the stigma of mental illness.

Dr Prani Shrivastava, FANZCA
Chair, Welfare of Anaesthetists SIG

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1. N.McDonnell, personal communication
2. Mortality of Doctors in Different Specialties, L Carpenter, A Swerdlow A, N Fear in Occupational & Environmental Medicine 1997;54:388-395
3. Cause-specific mortality risks of anesthesiologists, B Alexander, H Checkoway, S Nagahama, K Domino in Anesthesiology 2000 Oct 93(4):922-30.

Sydney trainee Dr Katherine Jeffrey wins 2011 Ray Hader Award



Trainee anaesthetist Dr Katherine Jeffrey has won the 2011 Dr Ray Hader Trainee Award for Compassion in recognition of her compassion and large contribution to the welfare of students and colleagues.

Adjudicated by ANZCA's Education and Training Committee and awarded by the ANZCA Council, the award is presented in the memory of a former Victorian trainee, Dr Ray Hader, who died in 1998

of an accidental drug overdose after a long struggle with addiction.

It was established by Dr Brandon Carp, a friend of Dr Hader, to promote a compassionate approach to the welfare of anaesthetists, their colleagues, patients and the community.

As well as a certificate recognising her achievement, Dr Jeffrey will receive \$A2000 to be used for training and education purposes.

A second-year anaesthetic trainee in Sydney's Prince of Wales rotational scheme, Dr Jeffrey's interest in her colleagues and fellow students began

while she was lecturing at the University of Sydney, and studying for her PhD. After coming across students who were struggling at university and felt unable to speak about their problems, she took on a mentoring role and began to lecture on surviving the world of science and medicine.

"I have been very lucky during my career as a junior doctor and now as an anaesthetic trainee to have been able to access resources for myself and other doctors to help them through difficult times and to find the right help," Dr Jeffrey says.

"Plus the access to an amazing mentor, who has guided me through the maze of training and experiences I have faced as a doctor since we met in 2008 when I was a resident in their team, has inspired me to 'pay it forward' to my fellow registrars so they too know they are not alone."

Dr Jeffrey has continued her work on the welfare of junior doctors throughout her career and has written many articles on the subject.

Dr Jeffrey was nominated by Dr Simon Martel and Dr Ahmad Bakir and is a very worthy recipient.

The award was presented by ANZCA President Professor Kate Leslie at a Christmas function at ANZCA House in November.

Trainee logbooks: the way of the future



All trainees will need to keep a logbook of cases from 2013 as part of the revised curriculum so it's a good idea to start recording cases now, according to members of the Trainee Committee.

Already, the majority of trainees are believed to use logbooks in some form, which range from paper-based logbooks and self-devised Excel spreadsheets, to electronic logbooks available on computers, smart phones and tablets.

While some trainees are collecting only enough data to meet the sessional requirements of current training

modules, from 2013 they will be required to keep records of each case to meet volume of practice requirements under the revised curriculum.

Queensland Trainee Committee Chair and final year anaesthesia trainee, Dr Brett Segal, is encouraging trainees to start keeping detailed logbooks now.

"It's good for the trainee, it's good for the hospital and ultimately it's good for the patient as well, with regards to safety," he says.

The type of information generally recorded in a trainee logbook includes patient age and gender, the type of surgery, ASA classification, anaesthetic procedures performed, level of supervision, time of day, and lessons obtained from the case.

Dr Segal started recording his operations as a trainee in the United Kingdom, where it is mandatory, and uses the Royal College of Anaesthetists' iGasLog on his smart phone.

He says an electronic logbook can help you collate reports on the types of cases you have been doing and identify gaps in your training. It is also useful when having a commencement interview with a supervisor of training when starting a new rotation.

Dr Segal says anaesthetists are known as being technically-minded, with the specialty required to use a range of machines such as ventilators and ultrasounds, and most have easily adapted to digital logbooks.

As he explains: "People joke about anaesthetists and their gadgets."

Popular electronic logbooks include the iGasLog and the Australian-based Vaper logbook, which also has applications for the Medicare benefits schedule and relative value guide.

However, Victorian Trainee Committee Chair and final year anaesthesia trainee, Dr Kym Saunders, prefers using her own Excel spreadsheet after a bad experience with an early-version iPhone application that could only be synchronised to an external internet site that crashed for two months.

She started a logbook after being strongly encouraged as a resident to keep records as a log of training time and cases, and has continued using one because of the many benefits.

"It's easy to get your modules signed off because you've got a clear documentation of each specialty," she says. "Also for your own personal uses to see if you've been a bit deficient in certain areas – if you haven't done enough arterial lines or CVCs (central venous catheters) under ultrasound guidance – as well as just keeping a record of interesting cases."

Dr Saunders says the best way to keep a logbook is to update it at the end of each day and not collect patients' stickers and allow them to accumulate and face the onerous task of trying to back-date case details when a module needs to be signed off.

Both doctors emphasise keeping a logbook will be important for trainees currently in the training program who will transition to the revised curriculum.



“If you’ve got proof that you’ve done half a module, then you’re more likely to get that time approved for the volume of practice requirements,” Dr Saunders says.

Acting General Manager of ANZCA’s Education Development Unit, Mr Olly Jones, says the numbers and types of cases that will be required under the volume of practice requirements of the revised curriculum are being finalised and will soon be publicised.

“The reason we’re doing it is to confirm experiential learning,” Mr Jones says. “It means every trainee records their experiences to demonstrate exactly what exposure they’ve had to different cases throughout their training program.”

“This means personal development plans and learning plans can be done in consultation with new supervisors every time they start a new rotation based on the information that’s there in black and white, as opposed to a lot of guesswork over the five-year training program.”

Mr Jones says the new logbook requirement will put structure into place for assessments and involves an element of standardisation to make sure all trainees have experiences that meet the requirements of the training program.

By logging every case, trainees will not only meet the volume of practice requirements, but also contribute to their own reflective learning by highlighting cases of significance.

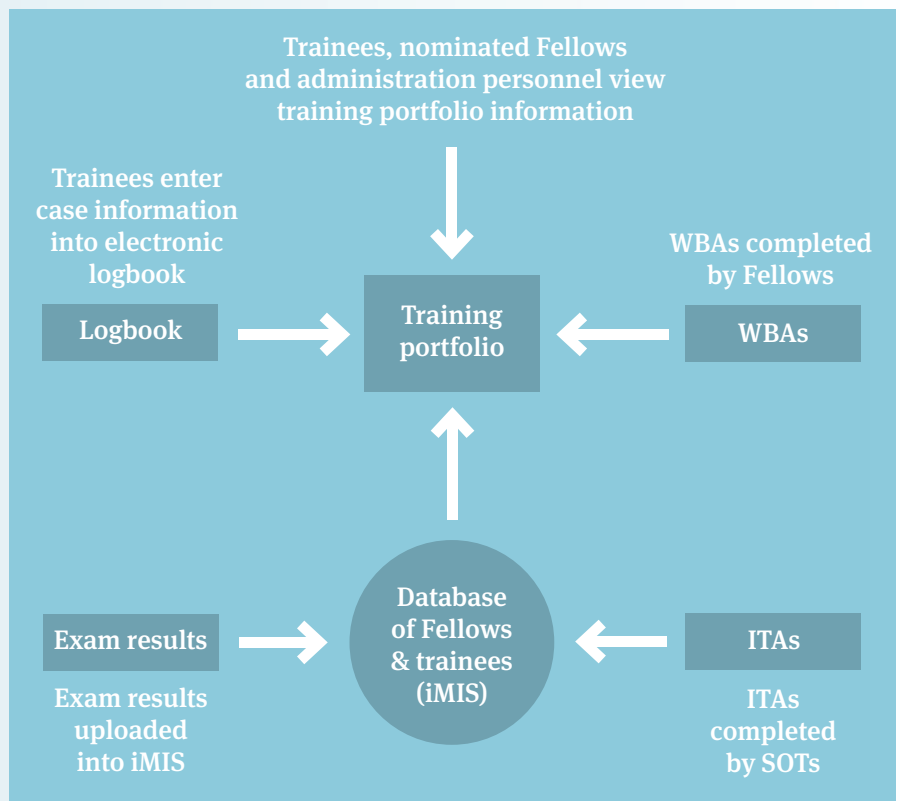
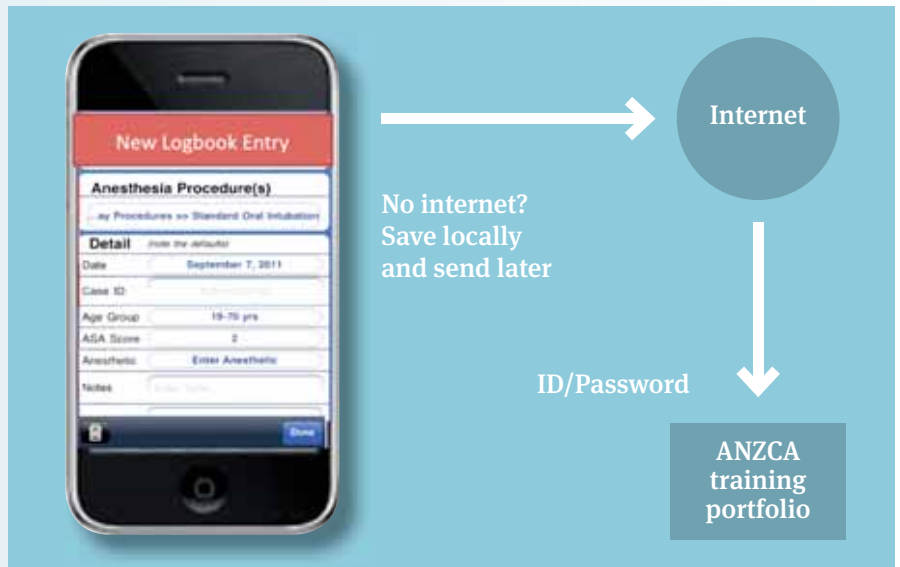
In addition, Mr Jones says it will help ANZCA fine-tune the training experience for trainees.

“From a curriculum evaluation point of view, if all of the cases are logged then it means that we can see if there are particular downfalls in our curriculum or holes,” he says.

“If every trainee struggles to get access (to a type of case), then it means we can do something about it and develop alternative resources or provide simulation opportunities. It means we know a lot more about the trainees and we can build bridges between the program in theory and in practice.”

Finally, Mr Jones nominates an additional benefit for trainees of keeping a logbook is gaining skills for the “manager” component of the “ANZCA roles”. “This is the first step really in preparing them for being effective administrators,” he says.

Meaghan Shaw
Media Manager, ANZCA



Above clockwise from left: Dr Brett Segal demonstrates his iPhone application to log cases he has been involved with; A smart phone logbook; A diagram of how the process might work.



ANAESTHESIA IN THE ACT

SPECIAL REPORT: HEALTH REFORM AND ANAESTHESIA
DEVELOPMENTS IN THE AUSTRALIAN CAPITAL TERRITORY

In this issue of the *ANZCA Bulletin* we continue our series on anaesthesia in state and territory jurisdictions.

(NEARLY) 100 YEARS AND GROWING



**DR CARMEL MCINERNEY,
CHAIR, ACT REGIONAL COMMITTEE**

The Australian Capital Territory is to celebrate its centenary in 2013. The site of the nation's capital was chosen after months of deliberation, a waste of a good sheep paddock perhaps, but it is now home to 400,000 people with many new suburbs being developed to accommodate the predicted population growth.

The Royal Canberra Hospital was built on what is now the site of the National Museum of Australia. Reflecting its origins in the Cold War, the operating theatres were built underground whilst the wards looked out over the Molonglo River and market gardens that were later flooded to become Lake Burley Griffin. In the 1960s, the Woden Valley Hospital was constructed to service the southern suburbs and in 1979 the Calvary Hospital, run by the nuns of the Little Company of Mary, opened to provide public and private hospital care to the northside. From the early 1970s, there were unaccredited jobs for aspiring primary candidates who, once successful, moved on to training places elsewhere.

Currently the good burghers of the ACT and region are served by a number of hospitals within the ACT. The "region" is south eastern New South Wales and overlaps the catchment areas for Wagga Wagga to the west, Albury to the south, Orange to the north and Bega on the far south coast, the ACT being an "island" surrounded by NSW. The major public hospital is The Canberra Hospital (TCH), the result of amalgamation of The Royal

Canberra and Woden Valley hospitals in the early 1990s at the Woden Valley Hospital site and now comprising 400 beds. It is the regional tertiary hospital for trauma, being the only designated trauma hospital west of the divide. This leads to pressures, particularly as the south coast of NSW is a popular retirement destination.

The Canberra Hospital provides all services except for paediatric cardiac surgery, major burns, solid organ transplants and interventional neuroradiology. It is the regional referral hospital for obstetrics with over 2000 deliveries annually. Planning for cardiac surgery began in the late 1990s with the first case done on cardiopulmonary bypass in early 2000.

On the northside, at Calvary Hospital, 200 public beds are co-located with a 160-bed private hospital. General surgery, ear, nose and throat (ENT), ophthalmic, obstetrics and gynaecology (O&G), maxillo-facial, and orthopaedics comprise the in-hours workload. Out-of-hours work comprises general surgery and O&G with approximately 1200 deliveries annually. Trainees benefit from exposure to different work practices in this setting.

There are about 160 other private beds spread among three more private hospitals. Across the territory's hospitals and day surgery facilities there are 42 operating theatres. Ten of these have been commissioned in the last three to five years and about 18 are in public hospitals.

There are over 60 anaesthetists in the ACT and there are still shortfalls. The area-of-need process has been ultimately beneficial to the Canberra anaesthetic community, despite the inevitable politics of such a process, with several highly regarded anaesthetists settling in the ACT. Their passage through the international medical graduate specialist (IMGS) process has been interesting for all parties but the hard work of many generous Fellows as well as the individuals concerned has been rewarded. Their hard work continues in key roles such as Dr Imran Ali in the Chronic Pain Unit, Dr Lisa Zuccherelli as Deputy Director of Anaesthesia at TCH and Dr Simon Robertson as the regional education officer.

ANAESTHESIA IN THE ACT CONTINUED



THE CLIMATE (CHANGE)

As with all hospitals in Australia, there is an inherent conflict in the pursuit of key performance indicators relating to meeting times for categories of elective and non-elective surgery. At TCH, over 60 per cent of the operating theatre caseload is non-elective, less than 50 hours of a potential 120 to 130 hours per week is designated emergency or non-elective operating time.

This inconsistency in resource allocation is a constant source of frustration and perplexity and no doubt familiar to all. The difference in the ACT is that excess workload cannot be dealt with by bypass to another institution: there is nowhere else for timely assessment and management of trauma. "Ramping" of ambulances is not an option as there are seven vehicles on the road as a minimum with two demand crews for busier times.

Certainly there has been recent huge investment in health with acquisition of a positron emission tomography (PET) scanner and on-table magnetic resonance imaging (MRI). Major building works at the TCH site are due for completion soon: a larger mental health facility including secure unit, and a women's and children's hospital (which will utilise the main operating theatres). For the present, Calvary Public Hospital continues to serve the rapidly expanding northside suburbs. In the future, there may be a third public hospital solely for elective surgery. However, the duplication of radiology and other services would appear to make this a more expensive exercise than first mooted.

As to the development of local hospital networks, ACT Health has expressed interest in developing these with Queanbeyan and Yass hospitals. However, the necessary negotiation between NSW Health and other involved parties makes this a very "far in the future" project.

TRAINING

Until the late 1990s anaesthetic services in the ACT were almost exclusively delivered by visiting medical officers (VMOs). As a result, the necessary conditions for provision of a training scheme were difficult to achieve. Nevertheless, as a result of the initiative and dedication of enthusiasts such as Dr Paul Christie, Dr Hugh Lawrence and Dr George Jerogin, these difficulties were gradually surmounted.

Accredited registrars from St George and Liverpool hospitals rotated for six months to TCH for their "rural" placement from the 1980s. Locally accredited trainees started with three positions in 1997. Negotiation with hospital administration for allowance for protected teaching time was an achievement which enabled a more structured approach that yielded success in both parts of the exam and led to the expansion in numbers to the current cohort of 26. Many who were local trainees have returned to work as consultants, a gratifying situation.

Rotations of four registrars annually to Albury on six-month placements commenced about 10 years ago. Despite the consolidation of obstetric services to Wodonga, necessitating travel across the Hume, it is a mark of the success of the rotation that several trainees have of recent years returned to Albury as consultants. Rotations to Calvary commenced in 2001, initially with just one registrar, now expanded to six anaesthetic trainees.

All modules can now be completed in the ACT scheme. In the recent past, it has taken some ingenuity to ensure adequate and equivalent exposure for members of occasionally larger than expected part 2 candidate groups. It is a credit to the efforts of the supervisor of training at the time, Dr Frank Lah, that no one was disadvantaged. He has served the trainees of the ACT tirelessly whilst being an exemplar of the art of anaesthesia. His efforts and those of all involved in registrar teaching and exam preparation were rewarded when a local trainee Dr Louise Ellard, was awarded the Cecil Gray Medal at the Christchurch annual scientific meeting (ASM) last year.

With respect to other support of trainees, a mentor program began a few years ago co-ordinated by Dr Natalie Marshall. More recently, the Group of Australian Society of Anaesthetists Clinical Trainees (GASACT) has organised sporadic social functions that aim to foster trainee collegiality.

The two departments of anaesthesia also provide anaesthetic experience for trainees from intensive care and emergency medicine, and training and refresher experience for general practitioner anaesthetists.

Medical students from the medical school at the Australian National University, and previously from the University of Sydney, are also beneficiaries of the time and knowledge of Canberra anaesthetists whether in lectures, tutorials, in the operating theatres or as examiners. Additionally, through the auspices of the John James Medical Foundation, medical students from James Cook University gain anaesthetic experience as part of a fully funded placement at the Calvary John James Hospital for their elective term.

CONTINUING MEDICAL EDUCATION

Canberra has gradually expanded in activity and in the number of anaesthetists. As a city-state, Canberra labours under the disadvantage of operating state sectional committees and activities (including training, continuing medical education (CME), other College activities, those of the Australian Society of Anaesthetists, and broader medical representation in bodies such as the Australian Medical Association) with the human resources of a small town.

Personalities such as Dr Ray Cook, Dr Hugh Lawrence and Dr Gerry Flynn took on much more than their fair share to advance the interests of anaesthetists and trainees alike. Dr Linda Weber, Dr Vida Viliunas, Dr David Kinchington and others have carried the baton into this century.

Left: The Canberra Hospital.

The annual scientific meeting, the "Art of anaesthesia", was the brainchild of Dr Cook and started nearly 20 years ago as a local event to coincide with Floriade, Canberra's spring flower festival. Proving popular and successful, it has evolved over the years under a succession of dedicated convenors such as Dr John Ellingham.

More recently, with Professor Thomas Bruessel as convenor, it has metamorphosed further to include international speakers and a change of season to autumn. This meeting often captures the anaesthetic zeitgeist and continues to attract broad interest.

The national scientific congress (NSC) of the ASA was held in Canberra in 1962, organised at a federal level. The next national meeting hosted in the ACT was in 1992: this was one of the first ASMs of the new Australian and New Zealand College of Anaesthetists, held with the Royal Australasian College of Surgeons (RACS) meeting.

The first locally organised national anaesthetic meeting to be held in Canberra was the ASA NSC in 2001. Despite several challenges including the events of 9/11, the meeting was a great success under the direction of such stalwarts as Dr Cook, Dr Lawrence, Dr Weber, Dr Viliunas, Dr Kinchington, Dr Nicola Meares and Dr Nick Gemmell-Smith.

Canberra will host the ASA national congress again in 2013, a significant centenary celebration! Dr Mark Skacel is the convenor and has already demonstrated great industry in the role. Dr Paul Burt is to be the scientific convenor and preparations are well under way.

RETRIEVAL SERVICES

The Capital Region Retrieval Service (previously known as Snowy Hydro Southcare Retrieval Service) is the local ACT aeromedical retrieval service that serves the ACT and region.

The service started in 1998 with two ACT ambulance service intensive care paramedics rostered to cover helicopter jobs each shift but doing the usual road work unless called out. It was soon appreciated that doctors brought additional and necessary skills and an initially ad hoc roster comprising surgeon, anaesthetists, intensivists and emergency specialists provided on-call services. In 2008, a review over six months, conducted into aeromedical services in the ACT, recommended adoption of the doctor-paramedic model for its standard level of care (as is the model of care elsewhere). This has taken several years to accomplish with most doctors now trained for winch and search-and-rescue work.

A new purpose-built base has just been completed which includes facilities for education, video-conferencing, training and accommodation for on-call onsite shifts. The variety, nature and amount of work has resulted in the service recently being awarded accreditation for six months of advanced training for trainees in both the College of Emergency Medicine and our College. These positions have been keenly sought and are already filled for next year.

As part of the trainee's placement, completion of a Pre-Hospital Trauma Course, Helicopter Underwater Escape Training (HUET), a directed fitness test relating to work activities and ground school (where they will be taught to become a member of the helicopter crew and become accredited in winching activities and search-and-rescue missions) is expected.

Overall it provides a very rewarding time that encompasses both the excitement of pre-hospital medical care in the aeromedical field with the specific training of the particular doctor's speciality and exposure to consultants from other specialities.



ANAESTHESIA IN THE ACT CONTINUED

VOLUNTEER WORK

Fellows have long provided anaesthesia services as volunteers to a number of organisations in places outside the ACT.

Dr George Jerogin travelled with Interplast teams for many years. A team consisting of neurosurgeon Dr Nadana Chandran, anaesthetist Dr Cliff Peady and two theatre nurses has visited Fiji to provide neurosurgical services for the past 11 years under the Pacific Island Project program.

Patients with requirements for tertiary or more protracted care have been treated at TCH with costs met by fund-raising and ACT Government support. Orthopaedic surgery has been the focus of trips to Timor by Dr Don Lu for the last two years under the ATLASS Program of RACS. Twenty procedures were completed on the most recent Timor trip on new patients and those whose treatment began on the previous visit.

Local paediatric surgeon Dr David Croaker and paediatric anaesthetist Dr Nick Gemmell-Smith have been to places as far away as Mongolia and Ethiopia where big cases were performed under a mix of halothane, ketamine and local anaesthesia. These trips have been under the auspices of Kind Cuts for Kids, a Melbourne-based charity.

The Specialist Volunteer Program is a local initiative established and funded by the John James Medical Foundation. This medical charity emerged from the sale of the operation of the John James Memorial Hospital under the guidance of Dr Peter Yorke, a local anaesthetist who trained in Hobart and has worked in Canberra for over 20 years. Dr Yorke was a significant driver behind the Specialist Volunteer Program and indeed made the first foray to Katherine with a team of orthopaedic surgeons. In recognition of his work for the foundation, as an administrator rather than as an anaesthetist, the clinical services building at the John James Hospital was recently named in his honour, a signal achievement.

The objectives of the program are to provide medical services in areas where there is a shortfall and its genesis coincided with the intervention in the Northern Territory. The target is 12 trips annually and the specialties involved thus far have been ophthalmology, paediatric dental surgery, ENT, gynaecology, orthopaedics and general surgery.

Support from the foundation has been generous with the purchase of an ultrasound machine for the gynaecologists and a portable slit lamp and tonometer for the ophthalmologists enabling the medical staff to perform point-of-care assessment in remote places. Specialist anaesthetists from the ACT including Dr Prue Martin, Dr Don Lu, Dr Vida Viliunas, Dr Phil Morrissey, Dr Stephen Brazenor, Dr James French and Dr Yorke have enjoyed providing anaesthetic services in places such as Katherine and Gove, and have been made to feel very welcome.

Anaesthetic registrars from Darwin have also formed part of the paediatric dental team and found the experience valuable.

So, in summary, life as an anaesthetist in the ACT provides many diverse opportunities to fulfill the roles of the profession as well as achieving a work-life balance that many in larger cities might envy.

DR CARMEL MCINERNEY,
CHAIR, ACT REGIONAL COMMITTEE

Dr McInerney would like to thank all who collaborated in compiling this article.



Above from top: Calvary Public Hospital; Dr Nick Gemmell-Smith demonstrating caudal anaesthesia in Ethiopia; Dr Ross Peake at the snow with the Capital Region Retrieval Service and at the beach; John James Memorial Foundation Board Chair, Associate Professor Paul Smith and Dr Peter Yorke.

Profile: Dr David Fenwick

The spirit of anaesthesia



Born in South Africa, angered by apartheid, Dr David Fenwick immigrated to Australia and became an anaesthetist, amateur sculptor and one-time boat-builder, and is now enjoying his second career as a retiree. He spoke to Meghan Shaw.

He's a little bloke, standing 40 centimetres tall. Mature of age, he is captured, striding forth, to practise anaesthesia and pass on his knowledge to others.

Cast in bronze, he is the centrepiece of a work called "Spiritus Anaesthesiae", which incorporates many of the ideals of anaesthesia.

Accompanying the sculpture is a bound book describing the work, its symbolism, how it was made, and an outline of the evolution of anaesthesia, training and practice.

They are the work of retired South Australian anaesthetist, Dr David Fenwick, who presented them to ANZCA President Professor Kate Leslie at this year's College Christmas function.

Dr Fenwick, 69, is a self-taught sculptor who started modelling as a hobby while working and has continued his passion into retirement.

He was born in South Africa, and did his undergraduate medical degree there, but was conscripted by ballot to the army as a general practitioner medico for a year, following which he was expected to complete 10 years of intermittent service.

"I was expected to enforce apartheid and I didn't think that was a good idea, so I immigrated to Australia," he explains.

"I grew up among the Zulus and I speak Zulu and I know their culture. And I felt that Africa was their land. It was not right for the whites to be fighting them for it. So I didn't like being part of the organisation that enforced apartheid."

Dr Fenwick recalls a feeling of unease about the enforced racial segregation from an early age.

"I can remember as an eight or nine-year-old the Africans coming to our gate and they knew I spoke Zulu and they would say to me, 'I'm hungry,' he says. "And they would say it in Zulu, 'Ngilambile inkosi', and 'inkosi' means a king. How degrading for a grown man to be calling a nine-year-old 'king' in their own country. So it was an uncomfortable feeling for a lot of my life.

"But having said that, it was a life of privilege and affluence at the expense of the blacks. We didn't see their privations because of apartheid, we were kept separate from them. But when I went to work at (the Chris Hani) Baragwanath (Hospital) in Soweto and I'd been up most of the night, they had beds in little rooms which overlooked a huge bus depot that used to serve Johannesburg. And there'd be a huge silent army gathering in the middle of the night to catch buses to go and work for a pittance in Johannesburg. And that wasn't good either."

So Dr Fenwick left in 1972 with his wife, Nancy, and two young children (one only two months old) and moved to South Australia, where they had another

son, and Dr Fenwick got a registrar position in Adelaide.

He trained in anaesthesia because he was interested in "something that was procedural but that was intellectual as well".

"There's a lot of medicine in anaesthesia, a lot of pharmacology, a lot of physiology, and that all attracted me. But it's also procedural, so you're actually doing things," he says.

He worked at the Royal Adelaide Hospital as a senior consultant until retirement in 2007, and in private practice. He also contributed to both ANZCA and the Australian Society of Anaesthetists (ASA), and was an examiner for the College, a tutor in Hong Kong (when the College was a faculty of the Royal Australasian College of Surgeons) and helped to organise rotations for Hong Kong students in Australia.

He always enjoyed modelling and making things for his kids, but it was while he was on the ASA council that he cast his first work in bronze, "Just Checking", a sculpture now at the ASA headquarters in Sydney.

Others followed, including "Airway", which he presented to the College in 2001, and a floating trophy for annual debates for the department of anaesthesia at the Royal Adelaide Hospital, which featured an anaesthetist checking a fiberoptic bronchoscope.

Dr Fenwick's latest work, "Spiritus Anaesthesiae", was inspired by wanting to highlight the contribution anaesthesia has made to advances in medicine and society.

"Anaesthesia has been such a pivotal event in medicine – not only because it has allowed surgery painlessly but because it has allowed an explosion of knowledge and scope in so many other fields of medicine," he says.

"I thought that the ideals of anaesthesia were worth putting together in some form, and so I thought of making a figure to embody those ideals."

The model is holding a book in his right hand, which represents the learning anaesthetists go through. On one page of the book is a brachial plexus to represent anatomy, and on the other page is a graph of the oxygen cascade to represent physiology.

In his left hand, he is holding a bowl of fuming liquid, which represents pharmacology and the practice and art of anaesthesia.



Around his neck is a stethoscope for monitoring, and a lanyard with a name badge to indicate he is properly trained and accredited. In his pocket is a pen for meticulous record keeping.

“I made him a mature figure, striding out so he’s confident not only from his training but from his continuing medical education – in his ability to not only practise anaesthesia but teach it to a whole range of people, not just other anaesthetists,” Dr Fenwick explains.

At the foot of the model are some books: one has the title “*Spiritus Anaesthesiae*” on it; another has “*Drugs*” written on it; and the third is a file with ASA, ANZCA and AMA written on it “to indicate that he’s prepared to work not only for himself and his own earning, but for the good of the whole profession”.

The book that accompanies the work explains Dr Fenwick’s motivation for making the sculpture, its symbolism, a history of anaesthesia, how anaesthetists are trained, and how the specialty has led to other branches, such as intensive care, pain, retrieval and hyperbaric medicine, and had input into other areas such as emergency and neonatal medicine. It also explains how anaesthesia has evolved and permitted a range of medical advances.

“(Anaesthesia) has allowed an explosion in surgery and transplant medicine because ... all those need anaesthesia,” Dr Fenwick says.

His close friend, a former ANZCA president and current Director of Professional Affairs, Dr Richard Willis, encouraged Dr Fenwick to return to

full-time practice at the Royal Adelaide Hospital towards the end of his career, where his breadth of experience, maturity and teaching were highly valued.

“He’s a highly principled anaesthetist who has a good dose of applied common sense,” Dr Willis says. “He sets himself a high standard in anaesthesia and expects others to do so as well.

“He’s been a big contributor to the profession and an excellent role model.”

In his spare time, Dr Fenwick teaches at the Medical School of the University of Adelaide and was also an adviser to the South Australian Surf Lifesaving and Resuscitation Council until changes by the registration board meant he was no longer allowed to provide medical advice.

He holds strong views about retirement and gave a workshop at a Welfare of Anaesthetists Special Interest Group meeting in 2008 on “Your second career: Achieving in retirement”.

“I believe very strongly that one should retire on the crest of a wave – both from the point of view of your own reputation but more importantly for patient safety,” he says.

“I decided to retire when I turned 65 and do other things, such as teaching at the medical school now. The relief of not doing clinical anaesthesia was huge because one worries about that disaster. It is so quick in anaesthesia that you have to really be on top of your game to retrieve the situation.”

Dr Fenwick has previously written a letter to *The ANZCA Bulletin*

recommending older anaesthetists appoint a younger buddy, who can report on rumours of declining ability to help them determine when it is time to retire.

“It’s better to retire a year too early than a day too late,” is his motto.

He also believes you need to prepare for retirement before it happens. “Medical life is so busy that it consumes everything and all you have time for is your family and your practice,” he says.

“You should keep a little bit of time for your art or learning or travel or whatever it is so you have an interest when you retire, and you don’t have to learn it at the time of retirement.

“In my case, I went off to a firm that allows you to hire a space and hire their expertise and to build a boat. And I built a cruiser for the Murray River, which my wife and I use. And while I was still young and I had my muscular strength, I learnt to use all the power tools and then I completed the boat in retirement.”

Recently, in September, Dr Fenwick and his wife cruised the Murray for two weeks. “The river was flowing, the bird life was back, there were echidnas and ‘roos. It was just fantastic.”

There can be few better ways to achieve in retirement.

Above from left: ANZCA President Professor Kate Leslie is presented with the sculpture by Dr David Fenwick; Dr David Fenwick and Dr Richard Willis; the sculpture; a detail of the sculpture’s book showing a brachial plexus and the oxygen cascade.

Assessing waste: An audit of pre-drawn emergency anaesthetic drugs



Dr Nathan Goodrick was awarded the Tess Cramond prize for his project “Audit of pre-drawn emergency anaesthetic drugs” at the 14th Annual Registrars’ Scientific Meeting held earlier this year and hosted by the Queensland Regional Committee.

Anaesthetists often draw up emergency anaesthetic drugs at the beginning of a list to facilitate their rapid administration in an emergency (or semi-urgent) situation. These “pre-drawn syringes”, anecdotally, are frequently left unused by the end of the list and are thus discarded.

An audit was conducted to quantify the usage and wastage of commonly pre-drawn emergency drugs at the Royal Brisbane and Women’s Hospital (RBWH). These pre-drawn drugs included metaraminol, ephedrine, suxamethonium and atropine. It was hoped that the results of this study would help determine the financial viability of instituting sterile pre-packaged pre-filled syringes that have an extended shelf life (hereafter referred to as pre-filled).

For a period of three weeks, anaesthetists were asked to record when they pre-drew agents for emergency use on an audit form placed on top of the anaesthetic trolley. If that syringe was subsequently used, a line was marked through the record. This enabled the amount that was drawn up to be recorded and also the proportion of the drug that was used and unused.

A total of 276 clinical sessions were analysed. In 198 (72 per cent) of these sessions one or more emergency anaesthetic drugs were pre-drawn. There were 70 sessions (25 per cent) that had no data recorded. No emergency drugs were drawn up for the majority of these lists but there are likely to have been a few instances where there were some pre-drawn but not recorded.

Metaraminol was the drug most commonly pre-drawn followed by atropine, ephedrine and suxamethonium. Over the audit period, 213 syringes of metaraminol were drawn up for emergency use. Of these, 106 were used while 107 were discarded unused. Thus, 50 per cent of pre-drawn metaraminol was wasted. For ephedrine, 124 syringes were pre-drawn, 42 were used and 82 (66 per cent) were unused. The results showed that 153 syringes of atropine were pre-drawn with just 13 used (92 per cent unused). Suxamethonium had 121 syringes pre-drawn with 11 of them used (91 per cent unused).

The primary goal of the audit was to obtain the total numbers of pre-drawn emergency drugs that are used or wasted at the RBWH over a three-week period. Despite the missing data, the results of this study provide some interesting findings and some preliminary support for the implementation of using packaged pre-filled syringes from a manufacturer instead of pre-drawn syringes.

With half of the pre-drawn metaraminol being used throughout the day, the majority of it is likely used in semi-acute scenarios rather than when no time is available to draw up this drug. Therefore an alternative strategy is to have packaged pre-filled syringes readily available for true emergencies and draw up metaraminol as needed for less urgent situations.

Like metaraminol, ephedrine was used relatively frequently and likely in semi-acute situations rather than true emergencies. Ephedrine was discarded unused more often than metaraminol in the audit (66 per cent versus 50 per cent of the time). This wastage makes ephedrine a particularly good target to be replaced by pre-filled syringes.

Suxamethonium was pre-drawn in over a third of lists and was used 11 times in only three weeks, however on only one occasion was it used outside of the emergency theatres. When used in emergency theatres the pre-drawn suxamethonium was used in situations such as emergency caesarian sections and other emergency cases requiring rapid sequence induction rather than in unforeseen circumstances such as laryngospasm or re-intubation.

The need for pre-drawn suxamethonium in the perioperative period has been questioned on other occasions¹. Suxamethonium can be drawn up rapidly in an emergency, as it does not need dilution and is infrequently needed outside of emergency theatres. Given these considerations, perhaps suxamethonium is being pre-drawn more frequently than it is needed at RBWH outside of emergency theatres.

Atropine was infrequently used during the trial and was administered 11 per cent of the time it was drawn up. It also already comes in a pre-filled formulation under the “mini-jet[®]” brand and it can be drawn up rapidly without dilution much like suxamethonium. For these reasons, the routine pre-drawing of atropine for all lists may not be justified.

It is acknowledged that the audit had limitations. The 75 per cent response rate makes it difficult to comment about the overall frequency of any particular drug been pre-drawn or not pre-drawn. However, the missing data should not greatly affect proportions used versus unused. Omissions could also occur when the use of a syringe was not recorded following the use of the drugs in an emergency situation. This would see the proportion of used emergency syringes increase.

The current way in which anaesthetists draw and administer injectable drugs in Australasia is idiosyncratic and relatively error prone^{2,3}. ANZCA has recognised this and made recommendations in College document PS51⁴ to reduce these risks.

Having pre-filled syringes available may also have safety benefits for patients⁵ by reducing drug errors being made in the rush to draw up and dilute drugs and by being more rapidly available in an emergency. It has even been suggested that all drugs could come in syringes instead of ampoules⁶. This approach has been pioneered in New Zealand by Professor Alan Merry and forms part of the SAFERsleep[®] System⁷.

Pre-filled syringes also have potential cost savings for expensive drugs. A trial of pre-filled syringes is under way at RBWH with a goal to roll out in all Queensland public hospital anaesthetic and emergency departments if the trial is successful.

Conclusion

Emergency anaesthetic drugs are frequently drawn up by the anaesthetist at the commencement of their lists at the RBWH and many of these pre-drawn syringes are disposed of unused at the end of the lists.

Metaraminol was the emergency drug that was most commonly pre-drawn, however it was wasted the least with approximately half of the syringes discarded unused. Ephedrine was pre-drawn about half as frequently and was discarded unused two thirds of the time.

Approximately 90 per cent of suxamethonium and atropine were left unused. With the large quantities of drugs being discarded, packaged pre-filled syringes that are not discarded until used may potentially be instituted with minimal monetary expense.

An additional expected benefit of these is improved safety, with a reduction of risk of errors when drawing drugs up in an emergency scenario and emergency drugs being available to all in emergency scenarios.

Dr Nathan Goodrick

Staff specialist anaesthetist
Royal Brisbane and Women's Hospital
Brisbane, Australia



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“Pre-drawn syringes, anecdotally, are frequently left unused by the end of the list and are thus discarded.”

ANZCA and government: building relationships

The policy capability within ANZCA continues to grow, supporting a strategic focus via the ANZCA policy team, which provides advice on policy development and strategy, and is responsible for liaison with government and related bodies.

Influencing policy

ANZCA's relationships with government agencies and key stakeholders, including national and state governments, medical councils and boards, continue to flourish. These relationships are fundamental to influencing policy development and debate, in turn benefiting Fellows, trainees and the community. Interactions have diversified, with increasing requests for ANZCA participation in consultations. A major achievement this year was a substantial increase in funding from the Australian Government.

Australian Government grants

Specialist Training Program

ANZCA has secured a grant through the Australian Department of Health and Ageing Specialist Training Program. The grant over two years comprises substantial funding for College administration and educational initiatives. The majority of funds will go towards trainee positions (37 in 2012) for anaesthesia, pain medicine and intensive care in private and rural/regional hospitals. The educational initiatives allow continued development of e-learning activities (podcast, webinars) and teacher training workshops. New funding has been secured for international medical graduate specialist (IMGS) support activities.

Rural Health Continuing Education Program (RHCE)

A grant of \$45,000 was awarded to ANZCA for the production of indigenous health podcasts to be led by the Indigenous Health Committee. The podcasts are to be developed by ANZCA and FPM Fellows and made available to other specialists through a joint College Indigenous Health and Cultural Competency Online Portal initiative being developed by the specialist Colleges with RHCE funding.

Improved policy capacity

Increased capacity in the New Zealand office means that the team can be more involved in interactions with the New Zealand Government. The focus is on further developing relationships with health sector agencies, and assisting with responses to consultation opportunities.

This year ANZCA provided advice to the Australian parliamentary inquiry into overseas trained doctors, demonstrating the College's commitment to continuous improvement in this area. The policy team also advised the Australian Department of Health and Ageing on issues arising from the implementation of the national health reform agenda, including e-health, specialist telehealth services, establishment of lead clinician groups, review of elective surgery and emergency targets, and the national performance and accountability framework. Advice was also provided to stakeholders such as the Pharmaceutical Benefits Advisory Committee, National Blood Authority, and the Medical Board of Australia.



The establishment of Health Workforce Australia (HWA) has required further engagement in the areas of workforce development, including the National Health Workforce Innovation and Reform Strategic Framework and the Clinical Supervision Support Program. Given the importance of these areas for the membership, ANZCA remains involved in ongoing discussions and looks forward to continued collaboration with HWA.

Health Workforce New Zealand has also been active, looking at ways to prioritise the disciplines for funding of medical training, and considering the role of alternative providers, such as physician assistants, as a way of boosting capacity. The policy team has provided support to ANZCA's New Zealand National Committee as it responds to these emerging issues.

Selected ANZCA submissions are available on ANZCA's website.

Re-accreditation of ANZCA in 2012

In 2012 ANZCA will be subject to re-accreditation as a specialist medical college by the Australian Medical Council (AMC) and the Medical Council of New Zealand. Work is under way on a substantial submission addressing the nine accreditation standards. The submission will be provided to the Specialist Education Advisory Committee of the AMC. A two-week inspection, which will include hospital visits, will follow in October next year.

John Biviano

General Manager Policy, ANZCA

ANZCA policy team

The recent appointment of a policy officer for New Zealand, Brigid Borlase, has brought dedicated policy support to the New Zealand office. In Australia, team members comprise John Biviano, General Manager Policy, Rebecca Conning, Policy Officer Professional Documents, Paul Cargill, Policy Officer Community Development (Indigenous Health and Overseas Aid), and Donna Fahie, the newly appointed Project Manager Specialist Training Program. Team members work closely with Dr Peter Roessler, Director of Professional Affairs (Professional Documents). All directors of professional affairs (DPAs) contribute to submissions by providing clinical and educational expertise across anaesthesia and pain medicine. The DPAs also represent ANZCA in a variety of forums. The policy team's expertise in the workings of government and understanding of the health landscape ensure ANZCA is engaged to best effect in this arena.



Malignant hyperthermia – an update



Malignant hyperthermia amongst the vines: MHANZ 2011 meeting report

Malignant hyperthermia

Malignant hyperthermia (MH) may retain a reputation as a terrifying spectre hiding in the shadows of clinical anaesthesia for some, but considerable progress has been made with the condition since it was described in 1960¹.

MH reactions are less frequent due to less potent triggering volatile agents, reduced use of suxamethonium and better education of MH families. Administration of total intravenous anaesthesia for MH susceptible individuals is now relatively straightforward.

Malignant Hyperthermia Australia New Zealand

Malignant Hyperthermia Australia New Zealand (MHANZ) is a group of specialist anaesthetists and scientists with an interest in MH, who are predominantly from the four Australasian MH testing centres (in Melbourne, Palmerston North, Perth and Sydney). The MHANZ group was formed in 2002 to share expertise across the Australasian testing centres and to advise anaesthetists on clinical matters relating to MH.

The annual MHANZ meeting was held this year in Masterton in the lower North Island of New Zealand. The meeting discussed a wide range of MH-related subjects, including several of interest to all anaesthetists.

“New” dantrolene

Pfizer is releasing a new formulation of dantrolene (Dantrium IV™) in Australasia late this year. After more than 20 years of concern about the difficulties of emergency preparation of this drug, improvements in the lyophilisation (freeze-drying)

process have significantly improved solubility in water. A flip-top vial and vacuum sealing (aiding addition of diluent) to the vial with a new orange label complete the changes to the presentation of the “new” Pfizer™ product.

There are no changes to: the dose per vial (20mg), the diluent (60 mL sterile water for injection) and the dose (2.5mg/kg increments regardless of age, with no upper dose limit).

“Old” formulation dantrolene will be replaced with Dantrium IV™ as stock expires.

Preparation of anaesthetic machines for MH susceptible patients

The purpose of “flushing” an anaesthetic machine prior to use with an MH susceptible (MHS) patient is to reduce the anaesthetic agent (AA) concentration to <5 ppm (a concentration considered “safe” by international MH experts). High fresh gas flows (10 Lmin⁻¹) are required during a “non-triggering” anaesthetic to avoid “rebound” of AA concentration to >5 ppm.²

The internal circuitry of new generation anaesthesia machines has become more complex and incorporates more plastic and rubber parts. These parts serve as a significant reservoir of anaesthetic gas, which is released back into the breathing circuit after anaesthetic discontinuation.²

New data on the Datex-Ohmeda Aestiva anaesthetic machine has been published this year² and Dr Chris Jones presented additional data on the Aisys anaesthetic machine at our meeting.

A mean flush time of approximately **60 minutes** is required to reduce anaesthetic agent to <5ppm for sevoflurane or desflurane in the GE Datex Ohmeda Aestiva and Aisys machines.

MHANZ members agreed that anaesthetic machines should always be prepared according to the manufacturer's instructions. In the absence of definitive manufacturer's data/instructions, conservative clinical practice is to **use a 60-minute flush time at 10Lmin⁻¹** (including the breathing circuit and ventilator) in GE Datex Ohmeda Aestiva and Aisys machines.

Activated charcoal filters

Published data³ describing the insertion of activated charcoal filters into the breathing circuit to absorb volatile anaesthetic agent was presented. The apparent efficacy of these devices appears to be promising but they are not yet available in Australasia. We expect more publicity on this topic.

MH iPhone "app"

The new iPhone MH application, developed by international MH experts Thierry Girard and Henry Rosenberg, was presented and discussed. The application aims to assist in diagnosis and treatment of an MH crisis. MHANZ members agreed this was a useful adjunct to the ANZCA-endorsed MH crisis task cards⁴ and was well worth purchasing (NZD 2.59) from the Apple iTunes App Store.

Case discussion and funding

The annual meeting is an ideal opportunity for group discussion on the results of diagnostic tests (the in vitro contracture test or IVCT) and to review the presentation of patients referred for testing. MH remains a difficult condition to clinically diagnose and sharing the collective experience of the group is invaluable.

Funding for the regional testing programs is an ongoing issue, with some administrators perceiving that MH diagnostic services are not core anaesthetic business. The group discussed funding strategies and how to involve anaesthetic trainees (with a view to succession planning) in MH investigation.

MH diagnostic testing

The IVCT remains the best available primary diagnostic test for MH diagnosis. A study⁴ by group members to demonstrate the safety of the negative result for the IVCT was presented and discussed.

The use of DNA analysis to identify MH genetic mutations has an increasing role in the investigation of MH. Progress has been limited in some centres by the complexity of the common MH-related genes and the costs associated with DNA testing. New techniques including "Next generation sequencing for mutation detection" were presented. Scientists and clinicians with expertise and knowledge in this area had animated discussion about newly discovered mutations and family pedigrees. Sharing of information within the group is vital to reduce repetition of research in different centres for this time-consuming and expensive process.

Researchers have sought a reliable non-invasive or minimally invasive diagnostic test to replace the invasive IVCT for many years. The use of cultured myotubes, B lymphocyte calcium release and skinned muscle fibres are experimental models that group members are currently exploring. They presented their progress to date.

Social activities

No MHANZ meeting would be complete without a few social activities. Everyone enjoyed an excellent dinner at Gladstone Vineyard and a visit to Stuart and Honor Henderson's olive grove in the picturesque town of Martinborough.

Dr Mark Waddington, FANZCA
Christchurch, New Zealand

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*The MHANZ MH resource kit (including task cards) is available to download at: <http://www.anaesthesia.mh.org.au/mh-resource-kit/w1/i1002692/> (This is also accessible under "Endorsed Guidelines" in the Resources tab of the ANZCA website, www.anzca.edu.au.)

Opposite page from left: An anaesthetic technician prepares a GE Datex-Ohmeda Aisys anaesthesia machine; the new Dantrium packaging.

Malignant hyperthermia – an update continued



We were recently invited to attend the inaugural conference on malignant hyperthermia (MH) in Jakarta, Indonesia, organised by Association of South East Asian Nations (ASEAN) countries and assisted by Dr Tae Kim, an anaesthetist at the John Hopkins Medical Institutions, Baltimore, US.

Some interesting and surprising facts were presented by some of the ASEAN speakers. Thirty-three suspected MH reactions were reported in a national survey in the Philippines in 2009 with a mortality rate of 33 per cent. In the subsequent two years, a further eight suspected reactions have been reported but this is only by word of mouth. Three of those patients died. Suxamethonium, halothane, isoflurane and a limited amount of sevoflurane are the triggering agents used in this country.

There is no central registry of MH cases and no facility for testing suspected MH individuals so it is difficult to precisely quantify the numbers of true MH reactions. Supplies of dantrolene are limited. While a conclusive diagnosis of MH is not possible without the in vitro contracture

test (IVCT), the extent of reported mortality is clearly disturbing.

MH reactions were reported to occur relatively regularly in Indonesia and a number of these were fatal. Indonesia also lacks a formal MH registry and has limited dantrolene supplies.

A case was presented of a mother who had a suspected MH reaction 30 years ago. She had survived without the use of dantrolene but she was not followed up. The patient did not remember this episode and her three-year-old daughter subsequently had an MH reaction during an ENT procedure. She survived but dantrolene was available.

MH reactions also have been reported in Malaysia and a recent fatal reaction in Brunei was described.

In New Zealand there are approximately one to two confirmed MH reactions per year although there are five to six suspected reactions each year and many more known susceptible patients receive anaesthesia each year. Approximately 300,000 general anaesthetics are given each year in New Zealand.

In Victoria, Australia, in 2010, nine MH susceptible patients were identified by IVCT after suspected reactions although some of these occurred in earlier years.

The last known death from MH in Australia was in 2003. There have

been no known fatal reactions in NZ since the early 1980s. This is due to a combination of dantrolene availability, improved monitoring (particularly the ANZCA requirement for capnography), increased anaesthetist and susceptible family awareness of MH and a registry of susceptible and suspected individuals.

In contrast, most ASEAN countries have limited supplies of dantrolene, limited monitoring and no diagnostic testing facilities. Educating anaesthetists needs to be prioritised and it is hoped the development of closer links with these countries will lead to improvement in MH management.

ANZCA supports a recommendation by the MHA NZ (Malignant Hyperthermia Australia and New Zealand) group that all hospitals where general anaesthesia is administered should stock a minimum of 24 vials of dantrolene (36 vials for large or isolated hospitals). Additional doses must be readily available on request. The dose for treatment of MH reactions is 2.5mg/kg (regardless of age) repeated every 10 to 15 minutes until the reaction is treated. Although the package insert states an upper limit, there is no maximum dose.

The reports from the ASEAN meeting highlight that MH remains a potentially fatal disorder. Only good monitoring and management and the ready availability of dantrolene has reduced mortality to its current level in Australasia.

Dr Neil Pollock (MHA NZ)
Palmerston North Hospital
New Zealand

Dr Robyn Gillies (MHA NZ)
Royal Melbourne Hospital
Australia

Dr Tae Kim
John Hopkins Medical Institution
US

Dr Barbara Brandom
University of Pittsburgh
US

Above from left: Dr Robyn Gillies (second from left), Dr Barbara Brandom (fourth from left) then Dr Neil Pollock, Dr Tae Kim, and two other ASEAN speakers.

BloodSafe eLearning Australia Postpartum Haemorrhage Course



BloodSafe eLearning Australia has recently released an online course to assist obstetricians, midwives, anaesthetists and theatre staff involved in the management of postpartum haemorrhage to have a greater understanding of its pathophysiology and prevention strategies and to assist in the management of postpartum haemorrhage (PPH).

PPH can be a life-threatening complication of vaginal birth or caesarean section and is a major cause of maternal morbidity and mortality in Australia, New Zealand and the rest of the world. Anaesthetists have an important role in resuscitation of the more severe postpartum haemorrhages in the delivery suite and in theatre where patients require surgical management to stop further bleeding.

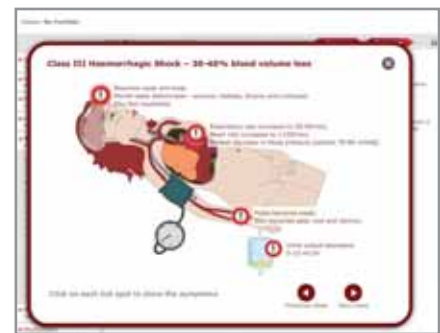
Bloodsafe eLearning is an online education program comprising several inter-related courses for health professionals. Their collective aim is to improve the safety and quality of blood transfusion. It is funded by the National Blood Authority on behalf of all Australian governments with approval via the Jurisdictional Blood Committee. It is supported by the National Blood Authority, the Australian Red Cross

Blood Service and the Australian and New Zealand Society of Blood Transfusion.

The Postpartum Haemorrhage course was developed by a multidisciplinary group of clinicians and has been reviewed by a panel including consultant obstetricians, consultant anaesthetists, a senior midwife, a haematologist and education specialists. It is based upon statements and guidelines from national and international colleges and societies and existing state-based maternity guidelines.

The course can be accessed via the BloodSafe eLearning Australia website, www.bloodsafelearning.org.au. It has six learning modules: 1) Physiology of pregnancy, 2) Cause, prevention, diagnosis, 3) Management of PPH, 4) Advanced fluid resuscitation, 5) Secondary PPH and 6) Anaemia Management. Each module has a multiple choice assessment requiring a 75 per cent pass mark. Once all the module assessments have been successfully completed, a certificate is forwarded to the learner to verify completion of the course.

The program could be particularly useful for trainees doing their obstetric anaesthesia module and working in departments providing anaesthesia for maternity services. It could assist



a department's tutorial program, for example, a case-based discussion – by ensuring a certain level of knowledge of the participants prior to the tutorial, or assist in revising material covered.

With the increasing competency-based training and governance over credentialing of medical staff, directors of anaesthetic departments providing cover for maternity services may wish to consider completion of the course as one of the minimum requirements before a trainee goes on to an after-hours roster covering the maternity service. The course would also be appropriate for Fellows wanting to update their knowledge of PPH. The course is category two, level one CPD activity with one credit per hour.

Dr Kym Osborn, FANZCA
Department Head, Women's
Anaesthetic Department
Women's and Children's Hospital,
North Adelaide

Above from left: Dr Kym Osborn shows the BloodSafe eLearning Australia Postpartum Haemorrhage Course to trainees Simon Roberts and Philippa Lane at the Womens and Children's Hospital, North Adelaide; Computer screen images from the course.

Reshaping New Zealand's health workforce



Professor Des Gorman has ruffled some feathers as he leads the review of New Zealand's health workforce. The Executive Chairman of Health Workforce New Zealand (HWNZ) wants to change the way trainee funding is allocated and has suggested a single medical college for New Zealand. Susan Ewart spoke to him.

The workforce service reviews have been described as needing to solve the 100/40/40 dilemma (that by 2020 there will be a 100 per cent increase in the demand for health services but, at most, only a 40 per cent increase in both staffing and funding resources). What is that 100/40/40 projection based on?

First of all, the term service review is a misnomer. Really, they are service forecasts by an inter-professional group of champions, and we are using their scenarios:

- to set in place a culture of inter-professional co-operative planning;
- to create an intelligence made up of clinicians who will step out of their day-to-day jobs and voluntarily contribute to a process of analysis and thinking and planning; and
- so that we can look at our planning and say that “of those possible scenarios, how many are we actually covering?”.

It is also a living thing in that we add to and subtract from the scenarios as we see alternatives becoming viable or current scenarios no longer having credibility. We also cull them against their ability to meet significant demand growth with only modest funding and workforce growth.

For example, one scenario is for optometrists to take care of glaucoma and macular degeneration. That's hugely attractive to us because there's enough spare capacity among optometrists for us to “buy” the next three to five years of productivity we need from an existing workforce. Also it may reduce the number of ophthalmologists we need to train by as much as half. That scenario has appeal then because this shift in the model of care enables quite profound productivity growth with only modest workforce growth.

A 100 per cent demand growth is our best guess for the next decade – but one based on some careful modelling of the effect of ageing in the community. It shows a demand growth of between 40 and 70 per cent over the next decade due to ageing alone, depending upon how well morbidity can be compressed in the latter years of life. If you add on other demand growth factors such as the “worried sick” middle classes – there is a huge investment in maintaining people's anxieties as these in turn drive service and product consumption – then a doubling of demand becomes predictable.

Small differences in model assumptions create significant variance in predicted outcome, so while it is based on careful modelling, because of the number of assumptions you have to make, calling it an informed guess is honest.

“The term perioperative physician seems more appropriate, while the name ‘anaesthetist’ seems misleading as it implies a narrow scope of practice”.

The 40 per cent workforce growth is based on the existing labour market. If we recruit five or 10 per cent more than currently, and we retain 80 per cent of the people going through training, and we look at current retirement patterns and the number of trainees we've got, what does that mean in terms of the size of the health workforce in 2020? The answer is that we would do well to get to 140 per cent of today's base by 2020. And that is optimistic. In fact, for most of the medical disciplines, we don't think we will get 40 per cent growth. Any growth is admirable in the context of an ageing community with fewer relative workers and greater competition for alternative jobs, and when you are trying to sell shift work to a lot of the putative workforce.

Finally, the funding growth projection and where that comes from. From 1950 to today, gross domestic product (GDP) in New Zealand has grown by 133 per cent, but health costs have grown by 417 per cent. We currently have an annualised increase in the wealth of our country of three or four per cent, but health costs are growing at something like eight or nine per cent accumulative per annum. In the last three budgets in New Zealand, half of all the new money has gone to health. The other 30-odd ministries, departments and services had to share the other half. Now that is just not sustainable. At some stage, we need to rein funding increases back in line with GDP growth and, if you do that, then we are looking at 40 per cent more funding over the next decade.

So the 100/40/40 conundrum is not speculative in the sense that it is made up just to alarm people. It is carefully determined.

I don't think we actually need to spend relatively more on health – it's about growing health spend commensurate with GDP. And it's not about saving money; it's about value for spend. I don't believe there is an appetite for saving money in health, nor is there a rationale for doing so.

What are the key issues for the anaesthesia workforce?

Well, it's interesting. I could not understand why there was so much angst among the anaesthesia workforce when we talked about physician assistants until much later when I realised that many anaesthetists saw it as a natural progression to the nurse anaesthetist. It is true that too much of our rhetoric was about tasks – the argument that some tasks anaesthetists do could be done by someone else.

However, what we failed to make clear is that we actually see the anaesthesia workforce as already being one of the most appropriately diversified and that nurse anaesthesia is not an attractive proposition to us. Any extension of nursing roles should be sensible in the context of nursing's core knowledge, skills, culture, values and practices. We actually think anaesthesia is an example of where not to take nursing extensions.

So we asked the New Zealand Society of Anaesthetists to do a forecast for us to help manage the anxiety about physician assistants and practice extenders, and to help us determine future training investment. The review was hugely helpful in illustrating several things.

First, the anaesthesia workforce is as diversified as we thought it was with anaesthesia nurses, anaesthetic technicians and perfusionists, as well as anaesthetists themselves, in the team.

Secondly, the problem is not the quantum of anaesthetists but their disciplinary and geographical distribution, which we can work on.

It was also hugely helpful having anaesthetists and anaesthetic technicians agreeing that there was probably an extension of the technicians' roles that would free up anaesthetists to do those things only a doctor can do.

Also, we think it showed that anaesthetists should take unequivocal responsibility for the whole perioperative experience, which a lot of them already do. The term perioperative physician seems more appropriate, while the name "anaesthetist" seems misleading as it implies a narrow scope of practice.

Someone having an overall guardianship role and providing continuity of care is clearly highly desirable.

If, as you suggest, simpler tasks are devolved to anaesthetic technicians, is there a risk that anaesthetists will lose access to some of the basic training upon which their higher level skills are based?

We don't have the insight or relevant experience to answer that question. What we would expect to see is a dynamic relationship between anaesthetists and their practice extenders.

There would be a scope of practice for the practice extenders but it would be for anaesthetists to decide on the maintenance of practical skills among the doctor workforce. We don't think the boundary has to be fixed.

The profession needs to understand clearly what it needs to do and what is genuinely substitutable; that view has to be tempered by the fact that you work in different sorts of environments with differing levels of support. Ultimately the profession has to be accountable for the way in which it configures its team so that we are largely getting genuinely doctor work out of doctors.

Do you see those practice extenders – and in this case, we are really looking at an expanded scope of practice for anaesthetic technicians – as always operating under supervision?

Absolutely. We are not advocating any non-integrated service models in any shape or form. Autonomous independent practice is an anathema to anyone planning future health services.

We are not saying which jobs should be allocated to the anaesthetic technician, but we are saying you need to have a look at what you think they can do.

We are also saying you have to be confident that you've undertaken that review bravely and that you can now define your role as a doctor largely by what can be done only by a doctor.

(continued next page)

Professor Des Gorman

- Born in Auckland of Ngapuhi and Pakeha descent.
- BSc (1975), MBChB (1978) and MD (all Auckland), PhD (Syd), the latter two involving brain injury research. As a physician, his interest has been in brain injuries and occupational medicine.
- PhD completed while serving with Australian Navy; dux of the Royal Navy Submarine School Officers' Course; Royal Australian Navy Officer of the Year.
- Director of Medical Services for the Royal New Zealand Navy 1989-95.
- Appointed head of the Department of Occupational Medicine at Auckland University's Faculty of Medical and Health Sciences in 1995.
- Has held a Professorial Chair in Medicine at Auckland University since 2000.
- In October 2005, appointed head of Auckland's School of Medicine, the first alumnus to head one of the five schools the faculty represents. Stepped down from that position in 2010 because of conflicts of interest with HWNZ work.
- During academic career, has had more than 250 papers published internationally and has made more than 70 keynote presentations to international conferences, most in health education and related disciplines.
- Was a Commissioner on Ministry of Health's Commission on Resident Medical Officers and chaired the Minister of Health's Taskforce that reviewed funding of health workforce training in 2009. Was also a member of the Welfare Working Group and the Veterans Affairs Expert Panel.
- Appointed Executive Chair, Health Workforce New Zealand, in 2009; is also a member of the National Health Board, including its Capital Investment Committee.
- Remains a Professor of Medicine at Auckland University and is Associate Dean at its Faculty of Medical and Health Sciences.

Reshaping NZ's health workforce

continued

You are health professionals, you have an obligation to the health system to take some responsibility here. And that responsibility is to have a view of how you work that is defensible – to Treasury, to the Prime Minister, to the other 30 departments and services who have to share half of the new money because health's got the other half. Your argument has to be viable in that real world context.

What is being done about the maldistribution and the loss of new specialists overseas?

The Advanced Training Scholarship offers support for new specialists to study overseas provided they return to a guaranteed job in New Zealand. In fact, this scheme is the institutionalisation of a long-held practice in which smart organisations have always sent people overseas and managed their return home. Unfortunately, over the last 20 years, different funding models have removed the obligation on health providers to nurture their future workforce. This is putting it back.

In terms of the maldistribution, the voluntary bonding scheme should help. It allows us to “wipe” the student loan of those who agree to train and work in areas of vulnerability, whether geographic or discipline. Now that the review has identified anaesthesia's geographic maldistribution, it could qualify for this scheme.

At the moment, HWNZ is funding about half the actual number of anaesthesia trainees – what is happening about trainee funding?

We are going to write to all the colleges soon and ask how many trainees they have, basic and advanced; how many they expect in 2012; and their maximum training capacity.

Instead of saying we are funding Jill but not John, and this training scheme but not that one, we are going to part-fund all trainees. We are going to pay a training subsidy or scholarship to the employers, but as each trainee is also meeting a certain level of service, we think there is an element of their activity we should not be funding.

So ultimately we will fund an RMO, say, at 25 per cent of their total costs because we think they provide a lot of service, or a basic anaesthesia trainee at 50 per cent because we think there is a lot of service slow down as a result of their limited skills and educational needs. Those numbers are used here as illustrations and will have to be sorted out, but basically we intend that every trainee will have a level of training subsidy that appropriately reflects their non-service work.

The other thing we are doing is identifying how vulnerable a workforce is – mainly the age of the workforce and the number of trainees, and how dependent the workforce is on immigrant doctors and on general registrants.

We are also looking at contribution in terms of the current and future health targets and we will give extra support to those disciplines that are both highly vulnerable and high contributors.

We understand that you are having a further look at the proposed prioritisation criteria?

The feedback has been terrific. We won't get the priority criteria right straight away, but we will get them as good as we can and we will ensure that they evolve.

Currently, funding is historical – those disciplines that were in at the time the former Clinical Training Agency was established, are in; those that were out, are out. For the last few years, we have gone to the minister and said we want you to sign off this purchasing plan but when he has asked what it is based on, we have had to admit that it is based on a rollover of last year's numbers. Not surprisingly, we have determined that we are not going to fund anything on the basis of historical precedent.

Irrespective of how close we are to getting it right, our process has to be transparent and accountable. We know we won't get it exactly right in the first year, but fear of not making it perfect shouldn't stop us from making it better.

“Many trans-Tasman colleges have a very Australian view and generally serve an Australian purpose at New Zealand's expense.”

Where are you at now with the single New Zealand medical college concept?

While it is not true of all colleges, it is a truism that many trans-Tasman colleges have a very Australian view and generally serve an Australian purpose at New Zealand's expense. That is a key concern for us. A New Zealand college with constituent academies that have scholarship partnerships, most likely with the various Australasian colleges, is clearly a solution.

However, there is an intermediate and preferable solution, which is that the Council of Medical Colleges (CMC) becomes an effective local pan-collegial executive, and we remain hopeful of that outcome.

It would streamline our consultation processes, but also, as an example, the most robust viewpoint about which of the medical disciplines are most vulnerable would come from a genuinely pan-collegial view. Otherwise every individual college will argue about being in need. I know it is quite demanding, but if the CMC can't develop a pan-college view of the most highly vulnerable, highly contributory health disciplines, then who can?

Historically, the CMC has stated that it does not have a health political or functional role, but we think there is a growing appetite for such roles. That would be our preference, but, in the interim, the concept of a New Zealand college of medicine remains on the table.

If the CMC did develop in that way, would you still have a problem with what you see as the Australian-centric nature of some trans-Tasman college?

Yes, but at least we would have a CMC operating as an intermediary and it would drive the colleges to have an increasing New Zealand focus. To us, it is the ideal solution because most New Zealand training schemes are too small to run by themselves.

Giving back to Asia and the Pacific



Consultant anaesthetist Dr Indu Kapoor has six weeks of leave without pay a year factored into her contract with the Capital and Coast District Health Board in Wellington, New Zealand – just so she can undertake volunteer medical missions in Asia and the Pacific. In the last two years, she has worked as a consultant anaesthetist with volunteer medical teams in Sri Lanka, the Philippines, Fiji and, most recently, Vietnam. Recently she talked to Susan Ewart about the work and its rewards.

How did you get involved in voluntary work?

I first got involved as a medical intern in India when I spent six months at a Fred Hollows' camp. Later, when I was a house surgeon, I worked as a junior doctor at a public health camp in Nepal, giving oral rehydration fluid to sick babies and teaching their mothers how to prepare clean ORS (oral rehydration solution). I completed my FANZCA in New Zealand, qualifying in early 2005, and now work at Wellington Hospital. I am a member of Oxfam 100, a social change group running from New Zealand. Being on this group has given me a unique insight into social and medical inequalities in the world and encouraged me to get involved. Last year, I was invited to take part in some voluntary work.

What was that?

I was the anaesthetist on a team that went to Sri Lanka as part of a continuing mission there. It was put together by Interplast Australia & New Zealand, a charity founded in 1983 as a joint project of the Royal Australasian College of Surgeons (RACS) and a Rotary district. Interplast sends teams of surgeons, anaesthetists, nurses and allied therapists to developing countries in the Asia Pacific region to provide medical training and free surgical treatment for those who otherwise could not afford it.

On our team, there were three surgeons, a general nurse, an anaesthesia nurse and me as the anaesthetist, mostly New Zealanders.

We spent two weeks in a military hospital in Colombo, working with a local medical team and specialising in

craniofacial injuries and deformities, including neurosurgery. In that time, we treated 19 patients, some with very big operations – one neurosurgical operation, for instance, could take a whole day.

A fundamental objective of Interplast is to help develop local capacity by providing training and mentoring programs for medical and allied health professionals. We were associated with a local team that Interplast had been working with for the last four years, and they are slowly being weaned off needing our assistance.

We will go back for a mission in 2012 but already there is enough expertise at that hospital for the local team to operate semi-autonomously. Interplast is also sponsoring one of its surgeons to train in Australia this year and New Zealand next year.

Where have you been this year?

In April, I volunteered with Operation Restore Hope, which surgically repairs cleft lips and palates for underprivileged children in the Philippines. We spent two weeks in a hospital in Calocan, south of Manila.

We had a much bigger team this time as we were not working with a local team. I was one of five anaesthetists, which made it easier because you could troubleshoot and debrief with the others whereas when you are on your own, you can feel relatively isolated. There were also five surgeons, four nurses and two technicians – volunteers from New Zealand and Germany. We did 88 cases and 120 procedures overall.

We took all the theatre equipment we needed, as we were allocated empty rooms to function as operating theatres! DHL shipped most of the equipment there for free for us and it is now being stored in the Philippines because this will be an ongoing mission. I have a commitment to go on this mission every two years.

Where else have you been this year?

In August I went to Fiji and in October to Vietnam.

The New Zealand Society of Anaesthetists funds a mission so that trainees in Fiji can attend the Pacific Society of Anaesthetists' annual meeting. As well as relieving with



clinical work during the day, I was teaching local trainees and medical students and engaging with them to see what their needs are.

I would like to see Pacific trainees have more access to ANZCA educational resources like the library, e-learning resources and podcasts as they are really short of those, and with the internet, it is cheap to provide them.

It was a fantastic experience. I worked with another anaesthetist from Wellington, Dr Narko Tutuo, who is originally from the Solomon Islands. This added another perspective to helping our neighbours in the Pacific.

Then in October, I went on another two-week mission, to a military hospital in Hanoi – this time with Operation Smile, a worldwide charity that provides free surgery to repair cleft lip, cleft palate and other facial deformities for children around the globe. We also had funding from AusAID and a single generous donor gave \$A50,000 for this mission.

This was very similar to the Sri Lanka work, in that we were doing craniofacial operations, mostly paediatric but some adults as well. And again it was about empowering local trainees – teaching them and slowly weaning them off needing us.

It was Operation Smile's sixth mission to this hospital. The first had a team of 31; this one had three surgeons, three nurses and one anaesthetist (me). This big decrease in the team was possible because the locals have become very good at operating and looking after

these patients. We are now looking at funding two doctors from Vietnam to have six months' training each in Melbourne.

I had a dedicated anaesthetic registrar allocated to work with me. To see her grasp the principles of craniofacial anaesthesia and improve in confidence over the two weeks was most rewarding. That contact is continuing by email.

Why did you get involved in voluntary work?

Growing up in India and my early voluntary work meant that I saw the number of people who get sub-standard care. I have the resources and the time to help out now, and maybe to make a slight change in others' lives.

It is incredibly rewarding work. In Sri Lanka, one woman came to us with half her face blown by shrapnel – she couldn't eat or breathe properly and was surviving on sips of water. The locals had no expertise to help her. She had no chin, no cheek, no tongue and no left eye, and had been on a liquid diet for about six months. The surgeons reconstructed all of this and by our last day had managed to get her breathing on her own. It was the most incredible procedure I have been involved in and it has completely changed that woman's life. She looked amazing the day we left, it was unbelievable and really, really rewarding.

(continued next page)

“It was about empowering local trainees – teaching them and slowly weaning them off needing us.”

Opposite page: Dr Indu Kapoor (left) with a trainee in Sri Lanka.

This page from left: Dr Indu Kapoor, second from right, with three Fijian trainees and a French anaesthetist, Dr Francoise Labat, a lecturer at the Fiji School of Medicine; Some of the Operation Smile team in Manila, from left: Indu Kapoor; anaesthetic technician Andrew from Auckland; Australian team nurse Emma; and Auckland anaesthetists Phil Wolstencroft (Starship Children's Hospital) and Craig Birch (Middlemore Hospital).

Giving back to Asia and the Pacific

continued



Do you find this work extends your experience in a way that you wouldn't get in New Zealand?

Yes, in all sorts of ways – the clinical skills acquired, the patient spectrum, the complexity of these cases, the disease process. Also working in an unfamiliar team, working with limited resources and doing it all while having to think on your feet and at all times maintaining patient safety and a high standard of care – it all helps me deal better with the changing and tricky situations at my regular place of work. One also appreciates and develops a healthy respect for all the resources we have here in New Zealand.

Volunteering brings a sense of “doing something worthwhile,” which in itself is a pretty good feeling!

Have you got plans for more volunteer work?

Yes, I am going back to Sri Lanka in April with Interplast and to Manila in 2013; and I hope to go back to Fiji to cover for the Pacific society meeting. I would also like to get involved in the Lifebox project with Professor Alan Merry (which provides pulse oximeters, and training on how to use them, to third world operating rooms).

I am very fortunate in that Dr Malcolm Futter, my Clinical Director, and my colleagues appreciate the skills I bring back to our department. I have six weeks' leave without pay factored into my contract. This makes it very easy to get time off for these missions.

“Volunteering brings a sense of ‘doing something worthwhile,’ which in itself is a pretty good feeling!”

From left: The youngest patient operated on during the Philippines mission – just six months old but amazingly co-operative; The facial reconstruction for this patient, who had lost half her face in a shrapnel wound, was “the most incredible procedure” Indu Kapoor has ever been involved in; Rewarding work – a nine-month-old boy in the Philippines, with a midline cranial cleft, immediately post-op.

New workplace laws – what they mean for you

Consistent, Australia-wide work health and safety laws have been drafted by the various state governments and are scheduled to come into effect next year. While there has been a strong indication that some states will delay the implementation of the new laws, they will ultimately be coming into effect and will apply to almost all workplaces in Australia.

The new laws mean volunteers will now be covered by work health and safety legislation, officers will have greater responsibility for workplace safety, and penalties for breaches will be substantially increased.

The new laws will also require widespread consultation with workers (including volunteers) about work health and safety issues.

Here is a quick look at what the changes may mean for you.

What are the changes?

The new Work Health Safety Act is broader in scope than previous laws and extends beyond the traditional employer-employee relationship to include new and evolving work arrangements, such as sub-contracting and the use of labour hire firms. As such, the term “employer” has been replaced by a “person conducting a business or undertaking”.

Who is now covered?

The types of workers now covered include employees, contractors or sub-contractors, employees of labour hire firms assigned to work in the person’s business or undertaking, outworkers, apprentices or trainees, work experience students, and volunteers. In summary, any person who is performing work of any nature for another person or organisation is a worker, and is covered by the act.

What are the responsibilities of persons conducting a business or undertaking?

They must, as far as is reasonably practicable, provide and maintain a work environment that is without risks to health and safety. As well as maintaining safe systems of work, this also means ensuring a workplace that is free from bullying and harassment.

What are the duties of officers?

The act covers officers, who are senior executives who make, or participate in making, decisions that affect the whole or a substantial part of a business or undertaking. Officers must be proactive and exercise due diligence to ensure the business or undertaking complies with its health and safety duties. While volunteers in officer positions must comply with officers’ duties under the act, they cannot be prosecuted for failing to comply with a health and safety duty, except in their capacity as a worker or “other person” at the workplace.

What about consultation?

A person conducting a business or undertaking must ensure that the business engages in consultation with all workers, including volunteers, labour hire employees and the employees of sub-contractors, about health and safety issues, including any proposed changes and identifying hazards.

What are the responsibilities of workers?

Workers must take reasonable care for their own health and safety, and ensure their actions do not adversely affect the health and safety of others. They must comply with instructions, and co-operate with policies and procedures relating to health and safety.



What are the penalties?

The penalties are based on the degree of culpability and the degree of risk and harm.

- The highest penalty, for a category one offence, occurs when a person is reckless as to the risk to an individual of death or serious injury or illness. The maximum penalty for a corporation is \$3 million; for a person conducting a business or undertaking or officer is \$600,000 and/or five years' jail; and for an individual is \$300,000 and/or five years' jail.
- A category two offence occurs when a failure exposes an individual to a risk of death or serious injury or illness. The maximum penalty for a corporation is \$1.5 million; for a person conducting a business or undertaking or officer is \$300,000; and for an individual is \$150,000.
- A category three offence involves a breach of the act that doesn't give rise to a risk. The maximum penalty for a corporation is \$500,000; for a person conducting a business or undertaking or officer is \$100,000; and for an individual is \$50,000.

When do the laws come into effect?

The laws are supposed to come into effect from January 1, 2012. However, Victoria and Western Australia have already indicated that they may not meet this deadline, and other states may also have delays.

Are there any differences between states?

There are a range of minor differences, but in terms of the major points of difference, Western Australia has not adopted the higher penalties of the act, while NSW has given unions the right to prosecute work health and safety breaches under certain limited circumstances.

What is the situation in New Zealand?

Under the Health and Safety in Employment Act 1992, all employers in New Zealand must take "all practicable steps" to ensure their employees are safe at work. Since 2003, the definition of employees has included volunteers who undertake regular duties for that organisation. "All practicable steps" includes providing employees with a safe workplace, and the information and equipment to enable the employees or volunteers to undertake their duties safely.

The act also requires that employees and volunteers themselves take all practicable steps to work safely, and to ensure that their actions don't harm others. This means that the responsibility for a safe workplace is shared by the organisation and the worker. The legislation covers situations where volunteers are working outside the employer's premises, for example, working at home.

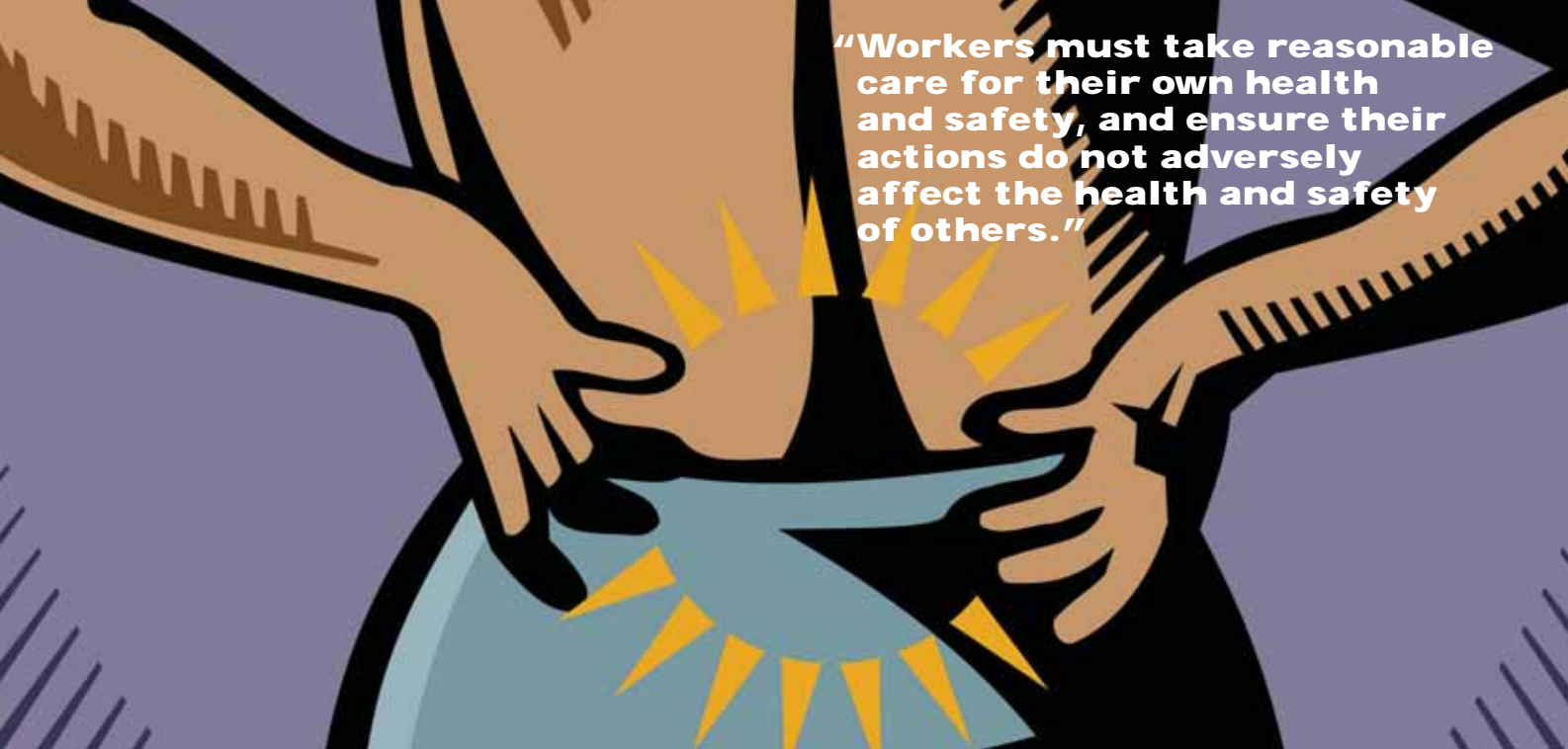
What does this mean for the College?

The College must ensure its officers, staff, Fellows, trainees and volunteers are aware of their responsibilities under the laws and consult on health and safety issues.

What does this mean for Fellows and trainees?

Anyone carrying out work on behalf of the College, including in a voluntary capacity, must comply with work health and safety policies and procedures.

(continued next page)

An illustration showing several hands of different skin tones reaching up to hold a glowing sun with yellow rays. The background is a dark blue-purple gradient with some white lines suggesting a sky or water surface.

"Workers must take reasonable care for their own health and safety, and ensure their actions do not adversely affect the health and safety of others."

New workplace laws – what they mean for you continued

CASE STUDY 1

A Fellow employed by a public hospital is supervising training on behalf of ANZCA. The Fellow is accused of bullying a trainee. The trainee becomes seriously ill as a result of the bullying and goes on leave. Who has duties towards the trainee and what are the likely outcomes of any prosecution?

The Fellow has a duty to ensure that his actions do not harm other workers in the workplace, and may have breached that duty. Both the relevant government health department and the hospital owe a duty to provide a safe workplace towards workers in the hospital. ANZCA has a similar duty towards people who may be affected by its undertaking of training. The officers of each of these three organisations all have duties to ensure that the organisations have adequate policies and training in relation to bullying. Any or all of these parties may be prosecuted if the regulator considers that they have breached their duties.

CASE STUDY 2

A self-employed Fellow suffers a needlestick injury after removing her gloves while still in theatre, however no infection occurs. How would this be viewed by the regulator?

The Fellow has a duty to take reasonable care for her own health and safety, by wearing appropriate protective clothing. She may have breached that duty by removing her gloves too early. The hospital has a duty to ensure that it has safe systems of work, including for self-employed workers who are performing work on its premises. If the hospital did not have appropriate policies and procedures in place, or had failed to ensure that the Fellow had undergone training and was aware of those procedures, the hospital may be in breach of its duties. While no serious illness has occurred, the Fellow was exposed to a risk of serious illness, so if there has been a breach of safety duties, the regulator may decide to prosecute and seek penalties against the Fellow (for her failure to take reasonable care for her own health and safety) and the hospital (if it has failed to ensure that there is proper training and induction for workers).

CASE STUDY 3

A Fellow who performs voluntary services on behalf of ANZCA is accused of harassing an ANZCA staff member with repeated and unreasonable requests. What is the likely outcome of any prosecution?

While the Fellow is a volunteer, he would still be a worker for the purpose of the act. Accordingly, the Fellow has a duty to ensure that his actions do not adversely affect the health and safety of other persons. ANZCA also has duties to ensure that it has provided adequate training and supervision to its staff and Fellows so as to ensure that they are aware of what constitutes inappropriate behaviour. The regulator may well prosecute the Fellow and, if ANZCA has not taken adequate steps to train its Fellows in relation to bullying, ANZCA may also be prosecuted and face penalties.

CASE STUDY 4

A New Zealand Fellow is doing a workplace-based assessment (WBA) of an international medical graduate specialist in Australia and hurts her back transferring a patient from the operating table. (Conversely, an Australian Fellow is exposed to the same risk in New Zealand.) Which laws apply and what would be the likelihood of any action by the relevant safety authorities? What are the responsibilities of the College to the Fellow?

Regardless of the nationality of the Fellow, the law of the country in which the incident occurs would apply. That is, the New Zealand Fellow would be subject to Australian laws and penalties, and the Australian would be subject to New Zealand laws and penalties. In either case, the hospital would be responsible for having adequate policies in place in relation to the lifting of patients, and the Fellow would be responsible for complying with those policies to ensure her own safety. If it occurred in a public hospital, the relevant health department would be also responsible for ensuring adequate resources are in place, such as appropriate lifting equipment and staffing. The College would have a duty to ensure that it inducted Fellows



into the WBA process and the need to comply with hospital policies (which may preclude participating in lifting by visitors). All four (the hospital, Fellow, College and health department) could be prosecuted if there was found to be a risk.

CASE STUDY 5

A Fellow corrects exam papers for ANZCA while working from home, and suffers a neck injury while working seated on a couch. What duties would ANZCA have towards that volunteer?

The Fellow's home is a workplace, in that work is performed there. However, it is not a workplace over which ANZCA has any real level of control, or an ability to supervise. ANZCA would have a duty to ensure that there is a safe work space available to the volunteer at his home, which it would discharge by inspecting the proposed working space. However, it is unlikely that ANZCA would be held responsible if the worker suffered an injury through working somewhere other than the proposed working space, such as on the couch.

Prepared with the assistance of Anthony Massaro from Russell Kennedy Solicitors.

Meaghan Shaw
Media Manager

Chairs give anaesthesia a seat at the big table

Australia and New Zealand can be justly proud of the number of internationally recognised researchers and academic work produced to further the reputation of anaesthesia and pain medicine.

Remarkably, this has been achieved with relatively few chairs of anaesthesia established at universities in our region, despite a significant number of Fellows holding appointments at associate professor and professor level in various departments.

Melbourne Medical School recently announced it is setting up an inaugural chair of anaesthesia. While the model for chairs varies from institution to institution, the benefits they bring to the profession are uniform.

In short, chairs raise the profile of anaesthesia and pain medicine, they influence the teaching of the specialties, and they contribute to ongoing research efforts.

ANZCA President, Professor Kate Leslie, says chairs are vital to the future of the specialties and the College is highly supportive of the development and retention of chairs of anaesthesia and pain medicine in Australia and New Zealand.

“Chairs are an expression of the value that universities place on our specialties of anaesthesia and pain medicine,” Professor Leslie says. “They make anaesthesia and pain medicine more prominent in universities and give us a bigger voice in medical student education. They also provide a focus for research efforts.”

In this day and age of advertising and spin, having academic representation is good PR for the specialties of anaesthesia and pain medicine.

A chair can help ensure resources are directed to teaching the specialties, get a seat at the table where the decisions are made that drive the universities, and help broaden knowledge of the specialties to other medical and scientific disciplines, including general practice, dentistry and nursing, and to the wider community.



Professor Kate Leslie
President ANZCA

“Chairs provide advocacy for the specialties of anaesthesia and pain medicine in universities to ensure they’re adequately addressed in medical student training.”



Professor Guy Ludbrook
Professor of Anaesthesia at the University of Adelaide and the Royal Adelaide Hospital

“A professor is a different beast to what he or she used to be many years ago and, as long as the role is well understood, I think a chair is a fantastic addition to any institution. We really should have more of them.”

“It’s really important for anaesthesia to be recognised outside medicine and outside universities as being a highly valuable and eminent pursuit,” Professor Leslie says.

In terms of teaching, a chair of anaesthesia can influence the student curriculum and clinical school placements, ensuring more students are aware of the specialties, especially pain medicine, which is under-represented in the curriculum of many medical schools.

They also provide a focus for post-graduate study, including doctors of medicine (MDs) and PhDs, ensuring there are future academic leaders coming through the system.

Professor Alan Merry, who has recently been promoted from leading the department of anaesthesiology at Auckland University to heading its School of Medicine, says one of his greatest achievements in the department was establishing anaesthesiology as a subject for PhDs.

“Prior to that, people who wanted to do PhDs at Auckland had to do them in subjects like pharmacology,” he explains. “They could do a study of

neuromuscular blockers or something like that, but they would get a PhD in pharmacology. Now they can do a PhD in anaesthesiology and that’s very significant because it makes a statement about the importance of anaesthesia generally.”

Professor Paul Myles, who chairs the Academic Board of Anaesthesia and Perioperative Medicine at Monash University and is also the Director of Anaesthesia and Perioperative Medicine at the Alfred Hospital, says chairs can ensure a focus for research and funding at an institution.

He lists his two main achievements as gaining National Health and Medical Research Council funding and developing perioperative medicine as a course for undergraduates and postgraduates, which also attracts physicians, surgeons and intensive-care specialists.

“That couldn’t have happened without these academic links,” he says.

“I’ve certainly found doors open a lot more easily (as a chair). I’ve been able to influence other undergraduate and postgraduate teaching and training in our specialties and develop further



Professor Alan Merry
Head of School of Medicine,
Auckland University

“You basically get a seat at the table where the decisions are made that drive the university. A chair opens doors and gives anaesthesia opportunities to provide advice and influence on a range of important areas, to the ultimate benefit of our patients.”



Professor Stephan Schug
Chair of Anaesthesiology in the School of Medicine and Pharmacology at the University of Western Australia and Director of Pain Medicine at the Royal Perth Hospital

“Having an academic representation of the specialty is a major PR issue in every aspect. It gives the opportunity to have influence on the academic system, it attracts more and better consultants to the place where the chair is, and it attracts students who would then try to become anaesthetic trainees.”



Professor Paul Myles
Chair of the Academic Board of Anaesthesia and Perioperative Medicine at Monash University and Director of Anaesthesia and Perioperative Medicine at the Alfred Hospital

“It is an illustration of recognition of academic seniority and with that comes respect for anaesthesia as an independent specialty.”

courses and other innovative ideas. It’s certainly assisted me in being successful in getting research funding.”

Professor Stephan Schug, who is Chair of Anaesthesiology in the School of Medicine and Pharmacology at the University of Western Australia and Director of Pain Medicine at the Royal Perth Hospital, says research by academic chairs has ensured anaesthesia has been at the forefront of patient safety.

“Because anaesthesiology has such a pronounced interest in patient safety and error management and error prevention, you can bring these topics of patient safety into the medical curriculum,” he says. “Anaesthesia is possibly the specialty that has the most pronounced expertise and interest in this area.”

Professor Guy Ludbrook, who is the Professor of Anaesthesia at the University of Adelaide and the Royal Adelaide Hospital, says the role of a chair is broad-ranging and evolving, and it is important for any institution establishing a chair to clarify the role and what is expected as “a professor is a different beast to what he or she used to be many years ago”.

“The recurring theme is about someone who’s prepared to consider problems and think about solutions, be prepared to challenge the status quo and be prepared to innovate,” he says.

While Professor Ludbrook says chairs previously were supposed to be a master of all trades – “whether research, teaching, the boss, the greatest clinician, the greatest strategist, the greatest politician” – these days one person cannot fulfill all those roles, and therefore the support of peers is crucial.

“That’s where the importance of chairs as being co-ordinators and collaborators and good team players is very important because all of those skills aren’t going to come from one person, they’re going to come from a group of people.”

Professor Ludbrook says anaesthesia is at an important point in its evolution in Australia and New Zealand where it needs to grow in the amount of work it does and also scope.

This is important because the specialty remains under threat, according to Professor Myles, by the squeeze on the health dollar by governments, bureaucrats and hospital administrators.

“If something’s not actually adding to the clinical service delivery, they see it as an optional extra, and academia generally and research often falls into that basket,” he says.

“I think we do ok (as a specialty). We do much better than some specialties, but we’ll always need to compete against the bigger specialties of surgery and medicine.

“We don’t need to try and be a dominant player, we just need to provide a quality service for that portion of space. And I think there’s room for all of that. In the past, we haven’t really taken full advantage of it and we’ve been perhaps crowded out by those big players. But I think there’s opportunity all the time.”

Meaghan Shaw
Media Manager

Fellowship survey – what's been done

A new, improved website and a more user-friendly continuing professional development (CPD) online portfolio are just two of the initiatives implemented by the College in response to the 2010 Fellowship Survey.

The survey, an initiative of ANZCA's Fellowship Affairs Committee chaired by Dr Michelle Mulligan and conducted by ANOP Research Services, was circulated last year to all active Fellows via mail and email and had an excellent response rate of one in two. In addition to the quantitative survey, ANOP conducted sessions with four focus groups at the 2010 Christchurch Annual Scientific Meeting.

The survey found there was a high level of satisfaction by Fellows with ANZCA overall (71 per cent satisfaction score). There was also strong usage of many of ANZCA's services indicating the College's relevance and value to the profession, and a high level of satisfaction with College staff (77 per cent satisfaction score).

However, there was room for improvement in other areas. Following are some of the initiatives that have been undertaken in response to the survey.

Website

The 2010 survey: There was a reasonable level of satisfaction among Fellows with the ANZCA website.

The Communications and IT units undertook a major project to update and redesign the ANZCA website, which was launched in September 2011. Content was updated and the new website offers better, more logical navigation.

Features of the new website include a more useful quality and safety section, a stronger presence for CPD, the library, the Faculty of Pain Medicine, the Anaesthesia and Pain Medicine Foundation and the international medical graduate specialists (IMGS) section, which now has easier-to-understand information.

An important new feature of the website is a comprehensive patients' information section.

CPD program, professional voice

The 2010 survey: Slightly lower levels of satisfaction were evident in survey responses relating to the College's CPD Program and ANZCA's role as the professional voice of anaesthetists.

A full-time CPD manager was employed in 2011 and several measures have been undertaken to improve the ANZCA CPD Program, including an overhaul and relaunch of the CPD online portfolio for Fellows.

The key changes include a redesigned ANZCA CPD portfolio homepage, easily identifiable menu items down the left-hand margin, clear and simple language, and ability to track progress and quick reference to any activity category that may require attention. A new CPD handbook has been developed.

ANZCA's role as the professional voice of anaesthetists, regarded as important by the surveyed Fellows, continues to grow with much work undertaken by the College's Policy Unit both in Australia and New Zealand, where a new policy officer has recently been appointed.

ANZCA makes regular submissions to government on behalf of the College and has had great success in attracting funding for important projects.

The Policy Unit also co-ordinates contributions to government inquiries such as the 2011 inquiry into overseas-trained doctors in Australia. A new section in the *ANZCA Bulletin*, "ANZCA and government", will inform Fellows and trainees of the work being undertaken by the Policy Unit on their behalf.

The Communications Unit continues to build the College's profile in the media, actively seeking positive coverage. ANZCA's media monitoring service estimates that a potential audience of more than eight million Australians and New Zealanders have heard, read or watched stories about anaesthesia or pain medicine as a result of the College's 25 media releases and approaches to the media on behalf of the College, to November this year.

Quality and safety, professional standards and education and training

The 2010 survey: The College's most important roles were seen to be quality and safety, professional standards setting, as well as education and training.

The new website has information relating to these areas prominently displayed, including a vastly improved quality and safety section where continuously updated safety alerts can be easily found. The *ANZCA Bulletin* and *ANZCA E-Newsletter* continue to have prominent quality and safety sections.

The section for international medical graduate specialists (IMGS) is now more informative, respecting the fact that English is not always the first language of many IMGSs.

The trainees section on the website has been updated and arranged more logically. Information relating to ANZCA Curriculum Revision 2013 has been given prominence, reflecting the importance of this project for the College and its commitment to training.

Also reflecting the College's commitment to training, the Communications and Training units established a new *Training E-Newsletter* in April, which is circulated among trainees, supervisors of training and heads of anaesthesia departments to help inform our trainees and their teachers.

The establishment of a Records Management Unit has enabled the College to streamline processes such as the new online in-training assessment (ITA) and online registration.

The College's Education and Development Unit has developed and delivered more e-learning resources with the commencement of a pilot for the ANZCA Teacher Course, designed to support anyone involved in the clinical teaching of ANZCA trainees.

The number of podcasts developed for trainees also continues to grow and are more easily found on the website. These e-learning resources and activities are regularly advertised in the *ANZCA E-Newsletter* and on the homepage of the website.

Professional documents, the ASM, library, publications and communications

The 2010 survey: Fellows saw particular strengths in the College's professional documents, the annual scientific meeting, the library, publications and communications.

Professional documents, which set standards within the profession, are more clearly displayed on the website. They are under constant review with six new or revised professional documents promulgated in 2011. Updates are communicated to Fellows and trainees via the *ANZCA Bulletin* and *ANZCA E-Newsletter*.

Library information is better displayed on the new website and new library publications are advertised in each edition of the *ANZCA Bulletin* and *ANZCA E-Newsletter*.

The annual scientific meeting continues to improve (the 2011 ASM in Hong Kong had one of the highest attendance records ever with more than 1600 delegates) with the Communications Unit producing a daily highlights e-newsletter for delegates and for Fellows unable to attend the meeting.

ANZCA's publications and communications are always being improved with experienced journalists writing and editing material. The publications are designed by the College's experienced designer to ensure a professional and consistent look.

Office holders, Anaesthesia and Pain Medicine Foundation

The 2010 survey: There was relatively low understanding among Fellows of the roles and responsibilities of office holders in the College, and low awareness of the Anaesthesia and Pain Medicine Foundation (formerly the ANZCA Foundation), particularly among new Fellows.

The new website has improved information about the roles of Council and committees (terms of references for each are now included) and there is a new "How to engage" section that also reflects the College strategy to "increase the engagement of the College's members".



A new General Manager, Foundation, Mr Rob Packer, has recently been appointed. The foundation has a more prominent location on the website and information is being redeveloped. There is a link from the "new Fellows" section of the website.

Pro bono work

The 2010 survey: More than half the Fellowship – 55 per cent of respondents – reported undertaking pro bono roles and nearly eight in 10 – 78 per cent – were involved in teaching roles.

ANZCA is undertaking a project to better acknowledge the pro bono activities of Fellows. In the meantime, the ANZCA President sends thank you letters to Fellows who are involved in running regional continuing medical education meetings and convenors send letters of thanks to course lecturers.

The ANZCA President also regularly acknowledges Fellows who contribute via her president's messages in the *ANZCA Bulletin* and the *ANZCA E-Newsletter*.

Subscription fees

The 2010 survey: Six in 10 Fellows regarded the annual subscription fee as reasonable or at least acceptable.

The College has sought to improve its communications with Fellows about the benefits of being a Fellow through a "Benefits of fellowship" brochure and improved communication regarding the annual subscription fee.

Work continues

Improvements to the website continue to be made.

The College will conduct a consumer survey in 2012 to gauge public perceptions of the profession. The results will guide the College on what to target in awareness and community education campaigns. Patient information sheets will be developed to build on the online patient information.

A project is also being undertaken to improve on the College's speed and responsiveness to Fellow's queries and to streamline administrative processes.

The next fellowship survey will be conducted 2013.

Clea Hincks
General Manager, Communications,
ANZCA

ANZCA announces 2012 funding for medical research



The ANZCA Council has announced funding of \$861,168 for research projects in 2012. The funding supports 14 project grants, two novice investigator grants, two continuing project grants including a scholarship, one simulation/education grant, one academic enhancement grant and the pilot grant scheme.

These exciting research initiatives will be carried out in leading hospitals and universities in Australia, New Zealand and Hong Kong and will continue to advance ANZCA's mission of serving the community by promoting safety and quality patient care in anaesthesia, intensive care, pain medicine and perioperative medicine.

Research awards

The **Harry Daly Research Award** has been awarded to **Dr Neil Pollock** for his project "Malignant hyperthermia: exome sequencing for gene discovery" (12/022).

The **Mundipharma ANZCA Research Fellowship** has been awarded to **Professor Paul Myles** for his project "ENIGMA-II trial long term follow-up study" (12/008).

The **Pfizer ANZCA Research Fellowship** has been awarded to **Dr Philip Finch** for his project "Investigating the adrenergic component of neuropathic pain" (12/024).

The **St Jude Medical ANZCA Research Fellowship** has been awarded to **Dr Paul Wrigley** for his project "Neurophysiological assessment of residual thermnociceptive sensation following spinal cord injury – a pilot study" (12/010).

*Clockwise from top left: Dr Megan Allen;
Dr Justin Skowno; Dr Daniel Mullany;
Dr Elsa Taylor; Professor Colin Royse.*

Project grants

Malignant hyperthermia: exome sequencing for gene discovery

Despite extensive research since the discovery of the main associated gene, malignant hyperthermia (MH) remains a potentially fatal complication of general anaesthesia in Australia and New Zealand, and across the globe. An MH episode can be avoided by use of specialised non-triggering anaesthesia in individuals known to be MH-susceptible.

Prior diagnosis can be made following a muscle biopsy, which is a highly invasive procedure requiring anaesthesia or preferentially by DNA testing, which requires only a small blood sample. The latter is available however in a limited number of families only.

The investigators have identified causative mutations and developed and implemented DNA-based diagnostic testing for many, but not all Australian and New Zealand families. This approach has been hindered because of the genetic complexity of the disorder as well as the observation that 20-50 per cent of affected families worldwide (including in Australia and New Zealand) do not have mutations in the main gene associated with the disorder.

This research will identify new genes associated with MH and characterise causative mutations, thus increasing the repertoire of DNA-based diagnostic tests available for prediction of MH-susceptibility.

Using state-of-the-art DNA sequencing technology, the genes in the human genome of MH-susceptible patients will be examined to identify novel genes associated with the disorder. Any identified variant will be tested for co-segregation with MH-susceptibility and exclusion from the general population. This information will provide the opportunity to develop and implement new DNA-based diagnostic tests for MH-susceptibility.

Dr Neil Pollock, Palmerston North Hospital, New Zealand, Dr Robyn Gillies, Royal Melbourne Hospital, Australia, Dr Kathryn Stowell, Massey University, New Zealand, Dr Teresa Bulger, Palmerston North Hospital, New Zealand

\$161,180 over three years

ENIGMA-II trial long-term follow-up study

This study will compare the long-term mortality/morbidity and persistent pain of patients enrolled in the ENIGMA-II trial who were randomised to nitrous oxide-free or nitrous oxide-containing anaesthesia.

ENIGMA-II is a large NHMRC-funded trial in 7000 patients, investigating the effectiveness of removing nitrous oxide from the anaesthetic gas mixture in patients with coronary artery disease undergoing major surgery.

The primary study hypothesis is that in patients undergoing anaesthesia for major surgery, avoidance of nitrous oxide will reduce the incidence of cardiac complications, stroke or death when compared with otherwise identically managed surgical patients receiving nitrous oxide as a component of their anaesthesia. It is strongly suspected that patients receiving nitrous oxide-free anaesthesia have lower rates of long-term morbidity and mortality than patients receiving nitrous oxide as part of the gas mixture for anaesthesia.

A follow-up study of the ENIGMA-II trial patients represents a unique opportunity to assess the effect of omission of nitrous oxide on long-term morbidity and mortality.

This study will undertake a medical record review and contact with patients to identify if any of the primary endpoints have been met. This will be a composite of death and major cardiovascular events and/or physical disability measured at one year after surgery.

It is also planned to measure and compare the incidence of persistent pain after surgery.

Professor Paul Myles, Alfred Hospital, Professor Kate Leslie, Royal Melbourne Hospital, Professor Matthew Chan, the Chinese University of Hong Kong, Prince of Wales Hospital, Associate Professor Philip Peyton, Austin Hospital

\$180,000 over three years

Methylalntrexone to prevent intrathecal morphine-induced pruritus after caesarean delivery: a randomised clinical trial (The MEAN ITCH Trial)

The majority of caesarean deliveries performed in developed countries are conducted under spinal anaesthesia. Intrathecal morphine has been used for pain relief after surgery, especially caesarean section, for several decades. The major limitation to this very effective way of relieving pain is the high incidence of morphine-induced side effects, especially itchiness, nausea and vomiting. Spinal morphine causes itch (pruritus) in 70-90 per cent of women: 20 per cent describe it as severe and 25 per cent request treatment to reduce its severity. This type of itch is particularly difficult to prevent or treat. Although itch is thought to be mainly a result of changes in the central nervous system, peripheral mechanisms outside the central nervous system also appear to be present.

Methylalntrexone is a new type of drug, which was developed to stop the peripheral side effects (for example, constipation) of opioids such as morphine, without reducing pain relief. This study is the first designed to investigate the potential effect of methylalntrexone in reducing intrathecal morphine-induced itch.

The study will establish whether this new drug is a useful means of addressing a very common and difficult to manage clinical problem.

Professor Michael Paech, King Edward Memorial Hospital for Women, Western Australia

\$40,273

ANZCA announces 2012 funding for medical research continued

Long-term anaesthesia cognition evaluation (LOTACE) study

Changes in memory and thinking are known to occur after surgery and anaesthesia, especially in the elderly, but the full extent of these changes over the longer term has not been studied. Since over a million anaesthetics are administered in Australia every year to individuals over 60 years old (those at risk), the investigation of cognition changes after anaesthesia and surgery is an important problem with far-reaching implications.

It is planned to test elderly patients two years after anaesthesia and surgery to identify if these changes in cognition persist over a longer time period. This is important because if patients do not fully recover all their mental function after anaesthesia and surgery, this may impact on their normal daily activities. Furthermore, it is planned to identify the severity of the changes in cognition. If the cognitive changes become so severe that the patient is unable to carry out simple tasks then such consequences become problematic. Specific tests will be administered after two years, which will test cognition, but will also detect if the patient has declined to the point of dementia.

The second part of the study addresses the cause of the cognitive decline. After many years of research, we know that cognitive decline is not the result of bad anaesthesia, low oxygen or poor blood flow. The most prominent explanation now appears to be that these individuals are susceptible to a form of Alzheimer's disease.

There is sound animal laboratory evidence that anaesthesia and surgery promote the Alzheimer's disease state. In humans, the fluid around the spinal cord carries certain proteins, which can identify who will get Alzheimer's disease. This is present many years before symptoms become evident but is able to identify those who will get the disease many years in the future.

We hypothesise that patients who develop cognitive changes in the longer term already have these proteins in the spinal fluid. Therefore, spinal fluid samples have been taken when spinal anaesthesia was administered for surgery. By analysing the proteins in these samples, patients who are susceptible to Alzheimer's disease will be identified. Thus, by comparing the spinal fluid results with the assessment of cognition two years after the surgery, we will be able to assess if the decline in cognition or presence of dementia was related to the incipient presence of Alzheimer's disease.

Associate Professor Brendan Silbert, Associate Professor David Scott, St Vincent's Hospital, Melbourne
\$60,000

Development of a behaviourally anchored rating scale to assess use of the WHO surgical checklist: the WHO's BARS Study

Patients continue to be harmed during anaesthesia and surgery (as well as in other fields of healthcare). Interventions involving checklists, the promotion of teamwork, briefing and debriefing and education to promote changes in culture related to patient safety have been shown to improve the safety of surgery.

One such intervention, The World Health Organization (WHO) Safe Surgical Checklist has been widely adopted around the world and is believed to substantially improve patient safety, but it is not known which, if any, of the above elements is critical to achieving its potential to save lives and reduce harm.

The aim of this project is to develop and validate an instrument, a Behaviourally Anchored Rating Scale (BARS) to evaluate how the WHO surgical safety checklist is being used in operating rooms.

It is planned to develop a BARS through an interactive process of consultation with the experts who developed the checklist. Observers will be trained to use the BARS using videos with simulations illustrating desirable and undesirable use of the checklist. Videos made from high fidelity simulations of appropriate anaesthetic and surgical scenarios will be used to validate the BARS.

Professor Alan Merry, Associate Professor Jennifer Weller, Associate Professor Simon Mitchell, University of Auckland, New Zealand
\$47,000

The influence of inspired oxygen concentration on oxidative stress, resolution of inflammation and lymphocyte subsets in human sub-lethal reperfusion injury

The focus of this investigation is to examine the effects of different concentrations of oxygen administered during surgery, on inflammation and perioperative infection risk. The immune system (particularly Natural Killer (NK) cells) becomes substantially deranged at the time of surgery. Usually this derangement is designed to cause inflammation which promotes healing. However, sometimes it can paralyse the ability of the body to defend against infection. Since infections following surgery have a dramatic impact on patients' long-term outcomes, it is important that we understand the effect of a simple and universal intervention on the immune system. Our preliminary work demonstrates that it is now possible to measure tissue toxicity directly attributable to oxygen tension, using compounds called isofurans. We will further explore the relationship between immune function and oxygen-specific free radicals in the perioperative period.

Associate Professor Tomas Corcoran, Professor Martyn French, Professor Trevor Mori, Professor Anne Barden, Professor Emilie Mas, Royal Perth Hospital, Australia
\$48,000

The optimal timing of preoperative smoking cessation

This project aims to determine the optimal timing of preoperative smoking cessation in patients undergoing a broad range of surgery.

It is generally accepted that smoking increases the risk of surgery and that preoperative smoking cessation should be encouraged. However, acute abstinence from tobacco may precipitate withdrawal syndrome and could complicate postoperative recovery.

A large, prospective cohort study will be conducted to determine the optimal period of preoperative smoking cessation and the impact of smoking (and its abstinence) on postoperative outcome. The study will identify the risk of smoking and will recommend an appropriate period of preoperative smoking cessation.

As millions of smokers undergo surgery each year, this will facilitate decision-making and will guide perioperative management worldwide.

Dr Matthew TV Chan, the Chinese University of Hong Kong, Prince of Wales Hospital, Hong Kong

\$43,000

Tissue perfusion monitoring in paediatric liver transplantation using near infra-red spectroscopy

This project aims to improve the safety of liver transplantation in paediatric patients by developing a Near Infra-Red Spectroscopy (NIRS) tissue oximetry-based protocol for hepatic monitoring post-operatively to ensure adequate hepatic perfusion after the transplantation process.

During and after liver transplantation, poor blood flow to the transplanted liver can have catastrophic consequences, including liver failure, brain damage and death. In liver transplantation, the health of the transplanted liver is assessed using daily ultrasound of the liver blood vessels and blood tests checking the liver's function. A continuous, real-time assessment of hepatic oxygenation status would be very helpful in guiding management and detecting acute vascular insufficiency.

NIRS uses optical techniques to assess average tissue haemoglobin oxygenation levels and thus assessment of the adequacy of blood flow in real-time. NIRS is used clinically in cardiac surgery to assess brain oxygenation during heart operations, and is used in many different areas of research into tissue oxygenation and perfusion.

The investigators are interested in applying this technology to monitor patients undergoing liver transplantation. A porcine model of acute hepatic ischaemia will be developed to test the ability of NIRS based tissue oxygenation monitoring to detect significant changes in hepatic blood flow.

Dr Justin Skowno, Dr Jonathan Karpelowsky, Professor David Little, The Children's Hospital at Westmead, Australia

\$41,000

An exploratory study of perceived risks, benefits and barriers to the use of selective decontamination of the digestive tract in Australasian ICUs (SuDDICU)

Selective decontamination of the digestive tract (SDD) is a therapy to decrease hospital-acquired infection, which may reduce mortality in ICU patients. SDD involves the application of antibiotic pastes to the mouth, throat and stomach and a short course of intravenous antibiotics. Despite strong evidence from randomised controlled trials and systemic reviews, this intervention has not been widely adopted by the ICU community in Australia and New Zealand due to fears that perceived overuse of antibiotics will lead to infections such as MRSA and *Clostridium difficile*.

This research program will involve parallel studies in Australia, New Zealand, Canada and the UK to explore and compare local and international perspectives on SDD.

The aim and objectives of the study are to identify the views of stakeholders (including intensive care consultants, senior nurses, microbiologists and ICU directors) about the current evidence relating to the use of SDD, with respect to clinical benefit, clinical risk, environmental risk and cost-effectiveness, the strategies that may overcome perceived barriers to the implementation of SDD and the acceptability and feasibility of conducting a randomised controlled trial of SDD in ICUs.

Dr Ian Seppelt, Professor John Myburgh, Dr Parisa Glass, George Institute for Global Health, Dr Andrea Marshall, University of Sydney, Professor Jeffrey Lipman, Royal Brisbane and Women's Hospital, Dr Jillian Francis, University of Aberdeen, Scotland, Professor Brian Cuthbertson, Sunnybrook Health Sciences Centre, Canada

\$42,000

Neurophysiological assessment of residual thermocceptive sensation following spinal cord injury – a pilot study

Injury to the spinal cord occurs more commonly in the younger population and has lifetime consequences for health and productivity.

Neuropathic pain remains one of the most difficult consequences of spinal cord injury (SCI) to manage. It is a major cause of suffering and adds to the physical, emotional and societal impact of the injury. Despite the use of best available treatments, two-thirds of people experiencing neuropathic pain following SCI do not achieve satisfactory pain relief.

Clinical examination has a limited capacity to detect partial fibre tract preservation following SCI. While neurophysiological tests are more sensitive, none are routinely available that assess temperature and pain transmission. A consensus approach for the assessment of sensory preservation following SCI, particularly subclinical spinothalamic tract preservation is yet to be achieved. Improved sensory assessment tools are desperately needed for ongoing SCI pain research.

This pilot project aims to determine whether contact heat evoked potentials (CHEPs) are able to detect subclinical spinothalamic fibre (STT) preservation following spinal cord injury (SCI). Aberrant activity from preserved spinothalamic tract fibres is proposed to be a crucial contributor to the maintenance of central neuropathic following SCI.

This research will improve our capacity to assess more objectively the neurophysiological pathways affected by SCI particularly those associated with the development of neuropathic pain. This in turn will assist in the development of rational treatment pathways for SCI neuropathic pain.

Dr Paul Wrigley, Associate Professor Philip Siddall, Pain Management Research Institute, Royal North Shore Hospital, Sydney

\$28,000

ANZCA announces 2012 funding for medical research continued

Investigating the adrenergic component of neuropathic pain

This study will investigate a crucial but neglected element in the mechanism of chronic pain that develops after injury to the central nervous system or peripheral nerve trauma.

In certain patients, a primary sympathetic deficit or secondary changes in sympathetic activity may alter blood flow and intensify inflammation. In addition, injury may increase the expression of α_1 -adrenoceptors on intact or regenerating nociceptive neurons, which, in turn, heightens their excitability to the sympathetic neurotransmitter noradrenaline. Interaction between these mechanisms could cause pain to spiral upward.

To test this hypothesis, skin samples will be obtained from patients in Australia, Germany and/or the USA with complex regional pain syndrome, painful diabetic neuropathy or post-herpetic neuralgia.

Immunohistochemistry will be used to determine:

1. Whether the expression of α_1 -adrenoceptors is altered on keratinocytes or nociceptive afferent fibres in the skin of patients with sympathetically maintained pain.
2. Whether heightened expression of cutaneous α_1 -adrenoceptors is associated with immunohistochemical signs of chronic inflammation.

Neuropathic pain is a common condition that is frequently misdiagnosed, difficult to treat and poorly controlled, as the mechanisms are not well understood. These studies will clarify the mechanism of sympathetically maintained pain in patients and open up new avenues for treatment.

Dr Philip Finch, Professor Peter Drummond, Murdoch University, Western Australia

\$30,000

“Light” versus “deep” sedation for elective outpatient colonoscopy: recall, procedural conditions and recovery

Colonoscopy is one of the most common medical procedures performed worldwide and in Australia it is usually performed under sedation administered by an anaesthetist.

Currently it is unclear what depth of sedation should be provided to optimise the balance between patient comfort, lack of procedural recall and safety.

While serious complications during sedation are rare, colonoscopy is performed so frequently that a strategy that is acceptable to patients, but results in fewer complications, would have a major impact on patient safety.

Colonoscopy is usually an outpatient procedure and so a sedation approach that allows rapid return to normal function without residual cognitive impairment is also desirable.

In this trial, consenting patients undergoing elective outpatient colonoscopy under sedation at The Royal Melbourne Hospital will be randomly allocated to receive either “light” (BIS 70-80) or “deep” (BIS < 60) sedation. Endpoints, including recall, complications, satisfaction and cognitive function will be assessed.

This study will provide guidance to anaesthetists aiming to deliver an optimal sedation strategy balancing patient amnesia, avoidance of complications and fast recovery. It is currently unclear how sedation for colonoscopy should be targeted with these goals in mind and this study will add to the current state of knowledge.

Dr Megan Allen, Professor Kate Leslie, The Royal Melbourne Hospital

\$19,000

Predictors of persistent postsurgical pain following total knee joint arthroplasty

Knee joint replacement is a common surgery, often performed in people with chronic arthritis. While knee joint replacement is an effective procedure in most people, many have ongoing pain lasting months or years after the surgery.

This study, involving researchers at North Shore Hospital, AUT University and the University of Adelaide, will try to better understand what factors predict the development of ongoing pain after knee joint replacement.

Three hundred patients scheduled for primary total knee joint arthroplasty will be included in the study. Patients will undergo preoperative testing of psychological, neurophysiological and genetic factors that may influence post operative pain outcome. Individual clinical information also will be collected.

The study will follow up knee replacement patients for six months to see how many still have pain at this time and which of the previously measured factors are significant and independent predictors of ongoing postsurgical pain.

Determining key factors that predict ongoing postsurgical pain will assist in the identification of at-risk patients who may benefit from targeted preoperative interventions, alternative anaesthetic or surgical protocols or more aggressive, individualised postoperative pain management protocols.

Dr Michal Kluger, North Shore Hospital, Professor Peter McNair, Dr Gwyn Lewis, Dr David Rice, AUT University, New Zealand, Professor Andrew Somogyi, University of Adelaide, Australia

\$18,000

Recovery and wellbeing after major surgery: complications, functional recovery and the measurement of disability-free survival

Anaesthesia studies typically focus on physiological measurements and recovery times, but this overlooks much of what the patient considers to be important in a good outcome after their surgery.

Adverse events are reported, but most are minor and transient. Cognitive functions are sometimes tested, but these have an unclear relationship to true dementia or disability.

Outcome studies suggest that a substantial proportion of people undergoing major surgery, particularly those who are elderly or have pre-existing morbidity, never fully recover and seem to have accelerated disability in the months and years that follow.

This project will evaluate a range of psychometric instruments measuring quality of recovery, quality of life and disability for up to one year after undergoing major surgery in order to develop a generic, validated measure of disability-free survival for patients.

Professor Paul Myles, Ms Sophia Wallace, Alfred Hospital, Dr David McIlroy, Columbia-Presbyterian Medical Center, New York, USA, Dr Mark Shulman, Royal Melbourne Hospital, Professor Jennie Ponsford, Monash University

\$30,000

Novice investigator grants

Hyaluronidase and peripheral nerve blockade – influence on onset time, extent of block and plasma local anaesthetic levels

This study will investigate the efficacy of hyaluronidase in the Fascia Iliaca Compartment Blockade (FICB) regional anaesthesia technique, examining the effect of hyaluronidase on the speed of onset and extent of blockade as well as the venous blood levels of the co-administered local anaesthetic.

In the FICB, local anaesthetic is delivered in the proximity of three target nerves – the femoral, obturator and lateral cutaneous nerve of the thigh – and it must spread a variable distance to block each of these. Frequently it doesn't reach one or more of these nerves in sufficient quantity to provide adequate anaesthesia.

This study will investigate the hypothesis that when hyaluronidase is added to a pre-operative, ultrasound guided FICB in patients undergoing unilateral knee arthroplasty it will increase the likelihood of successful nerve blockade.

Patients undergoing total knee replacement surgery will be tested in a randomised, controlled, blinded clinical trial. All patients will undergo ultrasound-guided FICB before the commencement of surgery with half of the patients having hyaluronidase added to the standard local anaesthetic.

The success of the blockade will be determined by testing sensation of the thigh and strength of the thigh muscles. Venous blood samples will be collected and plasma ropivacaine levels determined by gas chromatograph mass spectrometry. The effect of hyaluronidase will be established by comparing groups with appropriate statistical tests.

Dr Andrew Lansdown, Royal Prince Alfred Hospital, NSW

\$12,215

The paediatric pharmacokinetics and pharmacodynamics of parecoxib

Parecoxib is a non-steroidal anti-inflammatory drug used in paediatric practice, however the effectiveness and the appropriate dosing are unknown in children.

Two groups of children will be invited to participate in the study: children having tonsillectomy and children having orthopaedic and general surgery.

Children having tonsillectomy will be randomly divided into three groups. Each group will be given a different dose of the drug and pain following the tonsillectomy will be assessed and correlated with the blood concentrations of the drug and its metabolite.

The other group of children undergoing orthopaedic and general surgery will receive a 1mg/kg dose of parecoxib and blood assays taken over a longer period of time. This later group will allow the modelling of the elimination of parecoxib from the body.

This study will establish pharmacokinetic and pharmacodynamic data which will assist in the safe and effective use of parecoxib in children.

Dr Elsa Taylor, Starship Children's Health, Auckland, New Zealand

\$8000

Simulation/ education grant

Disposition of sedative, analgesic and antibiotic drugs during simulated extracorporeal membrane oxygenation

Extracorporeal membrane oxygenation (ECMO) is a salvage therapy for critically ill patients where a large percentage of the cardiac output flows through a circuit located outside the body. Oxygenation and carbon dioxide removal occurs and blood is returned providing respiratory and/or circulatory support. This is like a cardiopulmonary bypass machine but is continued for weeks rather than hours.

The extracorporeal circuit has been one of the major advances in modern medicine. Experience with adult ECMO is limited but use appears to be increasing.

Despite its major benefits, ECMO can induce a wide variety of pathophysiological changes in the body as the blood comes into contact with the non-endothelial artificial surfaces of the circuit. This may then substantially affect the pharmacokinetics of various medications. These changes can lead to therapeutic failure or drug toxicity both of which are deleterious to the patient.

It is believed that numerous patient and circuit factors play a role in altering the drug pharmacokinetics during ECMO. However these factors have not been fully evaluated in the context of current ECMO technology in critically ill patients.

The aim of this study is to describe the disposition of commonly used sedative, analgesic and antibiotic drugs during simulated extracorporeal membrane oxygenation in order to assist clinicians to develop evidence-based dosing schedules and better sedation protocols.

The study will aim to achieve the objective of determining the degree of sequestration of sedative, analgesic and antibiotic drugs in simulated extracorporeal circuit using a centrifugal pump and hollow fibre membrane oxygenators.

Dr Daniel Mullany, Dr Kiran Shekar, Professor John Fraser, The Prince Charles Hospital, Dr Jason Roberts, The Royal Brisbane and Women's Hospital, Professor Maree Smith, The University of Queensland

\$35,000

ANZCA announces 2012 funding for medical research continued

Academic enhancement grant

Cognitive decline following anaesthesia and surgery – is inflammation the cause?

Cognitive decline is a frequent morbidity and a major cause of poor quality of recovery following anaesthesia and surgery.

However, it is an area that could be targeted for interventions. Drugs aimed at modulating the inflammatory process can be tested in both animal and human experiments to identify if cognitive recovery can be improved. Successful follow-on translational research could improve recovery for a vast number of patients with flow on effects for less suffering and better use of national resources.

This project is a vital “proof of concept” investigation to determine if inflammation is an important cause of cognitive decline. The clinical significance is that further research can be done to investigate interventions to reduce the inflammatory response.

By giving drugs, or using different techniques it may be possible to reduce the impact of anaesthesia and surgery on brain recovery. We have already identified that the anaesthetic drug is an unlikely candidate as the most important cause of cognitive decline, but it is possible it may act as a promoter and enhance the potential for cognitive decline in susceptible individuals.

A surgical group will also be tested with two different anaesthetics to identify whether there is a greater degree of cognitive decline in the surgical preparation than just the inflammation preparation.

This academic enhancement grant will not only help to achieve this important piece of research, but will also help to build capacity for anaesthesia clinicians to embark on basic science research to improve their understanding of drugs and techniques that are used in everyday practice.

It will also provide capacity for anaesthetists to do research higher degree training.

Professor Colin Royse, The Royal Melbourne Hospital, The University of Melbourne

\$90,000

Grant review process

Thank you to all reviewers listed below who reviewed a grant, and in some cases two, for your invaluable contribution to the grant process. The ANZCA Research Committee is extremely grateful for your assistance.

Each year, the ANZCA Research Committee reads the grants, selects three reviewers for each grant on the basis of their expertise and relevance to the project, reads the reviews, collates the information and acts as spokesperson for each grant and a recommendation to the ANZCA Council.

The grant review process is rigorous and transparent. Conflicts of interest are recorded and members of the committee are excluded from consideration of any grants for which they have a conflict.

The presence of Dr Angela Watt, our community representative, adds an extra safeguard.

Research Committee members are:

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Dr Andrew Davies

Professor Tony Gin

Dr Chris Hayes

Professor Paul Myles

Professor Michael Paech

Professor Tony Quail

Professor Stephan Schug

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Associate Professor David Story

Professor Bala Venkatesh

Dr Angela Watt, community representative

Associate Professor Jennifer Weller

Dr Dan Wheeler

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Perth prepares program for a blockbuster annual scientific meeting



In six months Perth will be hosting the 2012 annual scientific meeting (ASM) on behalf of ANZCA and the Faculty of Pain Medicine.

The theme, “Evolution: grow, develop, thrive”, has inspired us to put together a meeting we hope will provide many highlights.

Central to any meeting’s success is the scientific program and the foundation of a program is formed by the contribution of the hundreds of Fellows and non Fellows who give up their time to be presenters and facilitators.

The invited guest speakers are the icing on the cake, and the significant contributions of these very accomplished individuals will add to the feel and texture of a large meeting.

The ASM organising committee has endeavoured to keep the scope and interests of the invitees as diverse as possible, so there is something for everyone. We have used the theme to focus strongly on experts who will deliver presentations to enable delegates to develop existing clinical knowledge and skills in a practical and relevant manner.

And now we can’t resist the opportunity to give you a sneak peek at what to expect in May!

To begin with, we were very excited when **Professor Ruth Landau**, from Seattle, accepted our invitation to be the ANZCA ASM Visitor. With diverse interests in acute and chronic pain, obstetric anaesthesia and genetics relevant to pain perception and pharmacology, Professor Landau was an obvious choice for the theme “Evolution: grow, develop, thrive”.

Associate Professor Andrew Davidson is the Australasian Visitor and was awarded the Lennard Travers Professorship for his work quantifying intravenous fluid maintenance and outcomes in children. Associate Professor Davidson is a paediatric anaesthetist with a very active role in research, is a member of the ANZCA Clinical Trials Group executive, and has editorial roles in both of the

journals *Anesthesiology* and *Paediatric Anaesthesia*. We look forward to hearing from him on several topics involving paediatric anaesthesia, anaesthesia research and its translation into practice.

Professor Patrick Wouters will join us from Ghent University in Belgium as the ANZCA WA Visitor, and will present in his areas of interest – cardiovascular anaesthesia and echocardiography. His extensive experience makes him an ideal contributor to the cardiology masterclasses (keep an eye out for the innovative masterclass series), and we look forward to his plenary on what is often the “second fiddle” of the cardiovascular system – the right ventricle.

The regional organising committee was pleased to have the opportunity invite an additional speaker this year as the “organising committee speaker” and has invited **Professor Joseph Neal**. Professor Neal is internationally renowned for his work in regional anaesthesia and pain medicine, and as editor in chief of the journal *Regional Anesthesia and Pain Medicine*. We are guaranteed an expert and extensive contribution from Professor Neal to both the ANZCA and FPM programs.

The FPM program will again stand out as a highlight of the ASM. The Faculty’s invited speakers, selected for their wide appeal to all aspects of anaesthesia and pain medicine, will kick off with the Refresher Course Day on May 11.

Professor Henrik Kehlet is widely respected for his contribution to pain and perioperative medicine internationally and will share his years of experience in chronic pain, surgical analgesia and recovery after surgery. **Professor Daniel Bennett** will join us from Colorado to discuss the topical problem of opioids in the community, and advances in neuromodulation and interventional pain management.

Following overwhelmingly positive feedback received at the combined SIG meeting at Port Douglas in 2010, we are delighted to welcome back **TRIAD**, a leading corporate, education and communication consulting firm founded by members of the Harvard Negotiation Project. TRIAD aims to help professionals understand how conflict,

negotiation, debate and dialogue happen in the real world and create tools that can be used in real time. The group is focused on relevant, practical solutions to the tricky situations we face each day, and they will be delivering a number of workshops (with limited availability, so book early!).

We also look forward to the plenary presented by **Mr Stevenson Carlebach** on the final morning of the meeting on the “Neuroscience of conflict and collaboration”.

The Western Australian Blood Management Program is a progressive local initiative with multiple international collaborations. Its focus is to minimise the risks associated with anaemia, iron deficiency, blood loss and transfusion, and we are fortunate that several seminal members of the program will deliver a number of presentations throughout the program addressing this universally pertinent aspect of our practice.

Finally, we welcome our industry-sponsored speakers. A meeting such as this would not be possible without the support of the healthcare industry and the industry has generously supported the presence of **Associate Professor Gregory Fischer** (who will present on cerebral oximetry) and **Professor Freidrich Puhlinger** (whose subspecialty interest comprises difficult airway management).

Organising a meeting of this calibre is an honour when it brings you into contact with individuals whose expertise and tireless effort extends the boundaries of knowledge and skill of our craft.

We thank all of our speakers in anticipation of their outstanding contributions, and we hope that we have whetted your appetite for the outstanding program put together by Scientific Co-convenors, Associate Professor Tomas Corcoran, Professor Michael Paech, and the Regional Organising Committee, Perth 2012.

Dr Tanya Farrell and Dr David Vyse, Co-convenors, ANZCA ASM 2012

The Lazarus Effect



Queensland resurrects its anaesthetic mortality review committee

I am pleased to advise that the committee to review anaesthesia-related deaths in Queensland has been re-established and will begin collecting data next year.

The decision to reform the committee follows persistent effort by former committee chair Dr James Troup, and the Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNET), and the focus on quality improvement within Queensland Health.

The Queensland Perioperative and Periprocedural Anaesthetic Mortality Review Committee (QPPAMRC) will focus on deaths that occur within 30 days of a procedure where an anaesthetist or health professional has administered anaesthetic drugs such as ketamine, propofol, thiopentone, fentanyl, midazolam, rocuronium and suxamethonium (not an exclusive list). It will cover operating theatres and the wider hospital in both public and private sectors.

A new format for reporting minimises duplication and has been developed to link in with existing Health Quality and Complaints Commission mandatory hospital death reporting requirements

conducted through the offices of Executive Director of Medical Services. We are aware that deaths outside the hospital are difficult to capture, however many patients are re-admitted and some hospitals are establishing processes to improve mortality-related feedback from GPs. The committee aims to capture as much of this data as possible and ultimately achieve a complete data set.

The QPPAMRC is being established as a gazetted quality assurance committee and as such, all information is treated in the strictest confidence and is not available through right to information laws. The committee and/or secretariat are prohibited from disclosing any information that may identify an individual who is a patient or health service provider, unless the individual has consented in writing to disclosure. The cases for committee review are de-identified by the QPPAMRC Secretariat before being presented to the committee.

The committee will provide de-identified data to ANZCA for inclusion in the national triennial report. The committee will also provide an annual report to the Minister for Health through the Patient Safety and Quality Executive Committee, identifying trends and issues and recommending quality improvement activities and methodologies for implementation. The endorsed reports will be forwarded to

SWAPNET for distribution to members and public and private stakeholders. Individual anaesthetists will receive a letter acknowledging participation to substantiate claims for CPD points and individual feedback will be available upon request.

Dr James Troup has been appointed as the inaugural chair of the committee, which will consist of nine permanent members drawn from anaesthesia bodies, surgical colleagues, anaesthetic assistants and pathologists and three provisional members relevant to the cases under review.

We encourage all anaesthetists to participate and look forward to publishing our first report in December 2012, although we are aware our data set will be incomplete for the first 12 months! For further information please contact the QPPAMRC Secretariat on +61 7 3131 6968 or QPPAMRC@health.qld.gov.au. A website with all the details will be available through the Queensland Health link early in 2012.

Dr Annette Turley, FANZCA
Co-Chair, SWAPNET

The Anaesthesia and Pain Medicine Foundation



New general manager starts work at the foundation

ANZCA has appointed Mr Robert Packer as General Manager of the Anaesthesia and Pain Medicine Foundation.

Rob, who started his new role in late November, joined the College from the Royal Botanic Gardens Melbourne, where he was Manager, Development for nearly five years. In that role, he was responsible for private sector fundraising and related marketing and communications for the Royal Botanic Gardens Board, Victoria.

Rob previously held senior management positions with the Brotherhood of St Laurence and World Vision's international, Thailand and Australian offices, and marketing roles at Ogilvy and Mather and Nissan Australia.

He has extensive experience in community sector marketing, relationship fundraising and partnership building, communications, public relations, direct marketing and brand development and management.

To make a bequest, become a patron and for all other inquiries, please contact the foundation office.

ANZCA House
630 St Kilda Road
Melbourne VIC 3004
Phone: +61 3 9510 6299
Fax: +61 3 9510 6786
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Tasmania

Dr GS Austin
Dr SK Swallow

Victoria

Dr AR White
Dr JM South
Dr JO Tang
Dr DJ Devonshire
Dr P Sivasubramaniam
Dr A Strunin
Dr AS Gunatunga
Dr MB Suss
Dr JJ Trinca
Dr GE Littlejohn
Dr TJ Rawdanowicz

Western Australia

Dr RJ Vaughan
Dr SY Fong
Dr KP Ahmat
Dr H Hamzah

New Zealand

Dr PM Templar
Dr TI Shum
Dr FH Stapelberg
Dr CJ Law
Dr SL Keel

Hong Kong

Dr MP Lee
Dr A Chu
Dr KS Cheung
Dr JM Low

Malaysia

Professor GS Ong

South Africa

Dr DA Roux

Switzerland

Dr E Parisod

United States

Dr SM Oh

Pilot grants

Applications are now open for the 2012 Pilot Grant Scheme, a fast-track program that is open to Fellows of the Australian and New Zealand College of Anaesthetists and the Faculty of Pain Medicine.

The program aims to assist Fellows to develop high quality projects with the potential to acquire future NHMRC funding, and to develop them into larger research studies. The scheme assists researchers in the areas of pilot-phase testing of trials, collection of baseline data using surveys or establishing a network of investigators.

Each year, the ANZCA Trials Group awards up to four pilot grants each to the value \$A5000, to a total of \$20,000. Pilot grants should not be confused with novice grants and are open to all Fellows throughout the year. Successful applicants have 12 months to take up their award from the date their pilot grant is announced.

Applications are adjudicated by the Trials Group Executive Committee and are judged on the following criteria:

- The quality of the research question.
- Appropriateness and feasibility of the research methodology.
- Justification of study as pilot research.
- Potential of the research to attract future competitive funding or the potential to develop the research into a larger study.

For the first time in the history of the scheme, four pilot grants were awarded in 2011. They were:

- Professor Julia Fleming. Intra-brachial arterial guanethidine for the management of Raynaud's phenomenon.
- Associate Professor Steve Bolsin and Dr Cameron Osborne. Geelong Rosuvastatin & Incidence of Myocardial Infarction Pilot Study (GRIMIP Study).
- Professor Paul Myles. Restrictive versus liberal fluid therapy in major abdominal surgery (The Relief Study).
- Professor Matthew Chan. Neurological impact of vascular events in non-cardiac surgery patients cohort evaluation study (NeuroVISION Pilot Study).

Applications for 2012 are open and researchers are encouraged to visit the website at www.anzca.edu.au/fellows/Research/trials-group/pilot-grant-scheme.html or contact the ANZCA Trials Group at trialsgroup@anzca.edu.au or spoustie@anzca.edu.au.

Survey research

In addition to its primary role of supporting multicentre clinical research trials, the ANZCA Trials Group facilitates survey research for Fellows and trainees while helping to reduce survey "fatigue" and protect the privacy of College Fellows and trainees.

In 2009 the trials group revised the required standards for reviewing and facilitating survey research for Fellows and trainees. This included a revised application form, re-writing the ANZCA Trials Group website (www.anzca.edu.au/fellows/Research/trials-group.html) to include more information and the addition of surveys that have been published or presented. The group has made a concerted effort to promote a high standard of survey research in College publications, at meetings and in scientific publications.

The ANZCA Trials Group has developed a policy for survey research in response to an increasing demand by special interest groups, Fellows and trainees. The policy outlines ANZCA's requirements for all survey research conducted and facilitated by the College. It will be available on the ANZCA website late this year.

Published surveys in 2011

McDonnell N. **Looking after our own: welfare of anaesthetists.** Australasian Visitor's Talk. Australian Society of Anaesthetists National Scientific Congress Sydney September 8-11, 2011.

Taylor M, Srinivasa S, Hill A. **Perioperative care in colorectal surgery – A survey of anaesthetists from UK, USA and Australasia.** Combined Scientific Meeting Hong Kong May 2011. Poster presentation: proceedings.

Taylor M, Srinivasa S, Hill A. **Goal-directed fluid therapy – A survey of anaesthetists in the UK, USA, Australia and New Zealand.** Combined Scientific Meeting Hong Kong May 2011. Poster presentation: proceedings.

Lee J, Wong C, Chuan A. **A survey of current knowledge and clinical experience of ultrasound techniques during FANZCA training.** Combined Scientific Meeting Hong Kong May 2011. Poster presentation: proceedings.

PeriOperative ISchaemia Evaluation-2 Study: POISE2 study update

Human Research Ethics Committee (HREC) approval for the POISE 2 study has been granted in Victoria (11 sites) NSW (three sites), Tasmania (three sites) and SA (one site). There are currently 29 participating sites in Australia and New Zealand undergoing or have obtained their ethics approval.

The Royal Melbourne Hospital has recruited the first patient in Australia – well done Professor Kate Leslie!

If you are interested in participating in POISE2, the ANZCA Trials Group will assist you with your ethics process, the Clinical Trial Notification and the Clinical Trial Agreements. If you are in Victoria, NSW or Queensland you may be added to the existing NEAF approval without having to undergo full HREC review.

Contact: spoustie@anzca.edu.au
or kate.leslie@mh.org.au.

New Zealand has a central ethics review system. Please contact Stuart Walker at Stuart.Walker@middlemore.co.nz.

New ANZCA Trials Group publications

Inconsistent survey reporting in anaesthesia journals. Story D, Gin V, Na Ranong V, Poustie S, Jones D. *Anesthesia and Analgesia* 2011; 113: 591-5.

Events



Annual Scientific Meeting

The ANZCA Trials Group has two sessions planned for the Perth Annual Scientific Meeting, and will hold its annual lunchtime meeting for all interested researchers on Sunday May 13. This meeting includes allied health attendees who are involved in current ANZCA Trials Group research. The meeting provides an excellent opportunity to meet with fellow researchers and hear updates and progress of studies.

There will also be a POISE 2 investigators meeting, which is open to existing investigators and their research coordinators, as well as those researchers who are interested in future participation.



Palm Cove Strategic Research Workshop

Following the success of this workshop in August 2011, the event will be held again in Palm Cove on August 10-12, 2012. This meeting was a huge success in 2011 with very positive feedback on the location, venue and content. Registrations and the program will be available in February 2012. The aim of these meetings is to present, mentor and encourage new ideas for multicentre research in anaesthesia, perioperative and pain medicine. There will be updates on existing research and next year we plan to have expert speakers again plus many leading anaesthesia researchers in Australasia. We encourage anaesthesia co-ordinators and allied health to attend and breakout sessions will be included for this group.

For more information on either of these two events contact: spoustie@anzca.edu.au.

College-approved anaesthesia indicators

Why is hypothermia in the recovery room valid (and important)?

ANZCA was asked to provide members to join a working party to revise the Australian Council on Healthcare Standards (ACHS) clinical indicators.

ANZCA's Quality and Safety Committee nominated Dr Margie Cowling, Professor Paul Myles and Dr Tracy Tay to provide this expert advice, and the ANZCA Council and Australian Society of Anaesthetists executive reviewed and amended the draft document before it was sent to ACHS.

This led to publication of version seven of the ACHS *Clinical Indicators User's Manual* in 2010.

Clinical indicators are measures of clinical process and/or outcomes of care. They are designed to detect potential deficiencies in care, but they do not provide specific information as to the reasons why such a deficiency may occur or whether or not such a deficiency led to an adverse outcome¹.

Clinical indicators typically rely upon the detection of statistical outliers, usually by comparison with a grouping of similar institutions based on their funding model (public/private), region and bed capacity. There is no specific attempt at adjusting for casemix or other aspects of complexity of care. They are perhaps best used to compare results within a single institution over time.

The College or ACHS is sometimes asked to explain why certain indicators are recommended, and how they are best measured. One of the most commonly considered has been Anaesthesia Clinical Indicator 3.3, relating to inadvertent hypothermia in the recovery room.

There is substantial evidence in the literature that maintenance of normothermia during major abdominal surgery may lead to improved outcomes. Avoidance of hypothermia reduces wound infection after colorectal surgery, and this is associated with a reduction in hospital stay¹. Other studies have found that hypothermia worsens blood loss and increases the need for blood transfusion, adverse cardiac events, shivering and can lead to delayed recovery³⁻⁶.

ACHS noted that the most recent experience had suggested an overall improvement in care across Australia, with the reported incidence falling from 0.81 per cent to 0.17 per cent. But the previous definition of hypothermia had been based on a temperature in the recovery room of less than 35 degrees Celsius. The ACHS working party chose to amend this definition to be consistent with the latest evidence identifying a temperature less than 36 degrees Celsius being associated with adverse sequelae²⁻⁶, and that it was advisable to maintain body temperature during and after surgery to at least this value. Other experts and national guideline bodies have made similar recommendations^{7,8}. It is for this reason that the definition of this indicator is as follows:

1. Numerator: Total number of patients admitted to the post-anaesthesia recovery room with a temperature recorded in the recovery period of less than 36 degrees Celsius, during the time period under study.
2. Denominator: Total number of patients receiving post-anaesthesia care who are admitted to the post-anaesthesia recovery room, during the time period under study.

Obviously this modification to the definition of hypothermia in the latest ACHS user's manual will result in an

increased incidence for this clinical indicator. This should not lead to a conclusion of a decline in quality of care at institutions that have previously used this indicator, because it will confound any attempt to benchmark within or across institutions if comparing with previous reported incidence rates. It will however provide greater opportunity to improve care even further into the future.

Professor Paul Myles
Clinical Indicators Portfolio
Quality and Safety Committee

References:

1. Haller G, Stoelwinder J, Myles PS, McNeil J. Quality and safety indicators in anesthesia: a systematic review. *Anesthesiology* 2009; 110:1058-75.
2. Kurz A, Sessler DI, Lenhardt R. Perioperative normothermia to reduce the incidence of surgical wound infection and shorten hospitalization. *N Engl J Med* 1996; 334:1209-15.
3. Bock M, Muller J, Bach A, et al. Effects of preinduction and intraoperative warming during major laparotomy. *Br J Anaesth* 1998; 80:159-63.
4. Schmied H, Kurz A, Sessler DI, et al. Mild intraoperative hypothermia increases blood loss and allogeneic transfusion requirements during total hip arthroplasty. *Lancet* 1996; 347:289-92.
5. Schmied H, Schiferer A, Sessler D, Meznik C. The effects of red-cell scavenging, hemodilution and active warming on allogeneic blood requirements in patients undergoing hip or knee arthroplasty. *Anesth Analg* 1998; 86:387-91.
6. Sessler DI. Temperature monitoring and perioperative thermoregulation. *Anesthesiology* 2008;109:318-38.
7. Vimlati L, Gilsanz F, Goldik Z. Quality and safety guidelines of postanaesthesia care: Working Party on Post Anaesthesia Care. *Eur J Anaesthesiol* 2009 Apr 22.
8. National Institute for Health and Clinical Excellence (NICE) Guidelines on management of inadvertent perioperative hypothermia in adults. www.nice.org.uk/CG65.

New accreditation regime throws doubt over future of Australian Council of Healthcare Standards

The Australian Council of Healthcare Standards (ACHS) is an independent, non-profit organisation dedicated to improving the quality of healthcare through continual review of performance assessment and accreditation.

The organisation was established in 1974 in Sydney after pioneering work from professionals, including the Australian Medical Association, medical colleges and the Australian Hospital (now Healthcare) Association.

A committee drawn from peak bodies in health, government and consumers determines the standards for evaluation, assessment and accreditation.

The ACHS Evaluation and Quality Improvement Program, EQuIP, was launched in 1996 and is the framework by which ACHS accredits healthcare organisations. EQuIP is purchased from ACHS by healthcare organisations.

Clinical indicators form part of the EQuIP accreditation process. ACHS and ANZCA establish a working party every five years to set the anaesthesia-related clinical indicators. The latest set of 16 anaesthesia-related and evidence-based clinical indicators was put together in 2009 by a working party consisting of Margaret Cowling, Paul Myles, Tracey Tay and non-anaesthetic members selected by the council.

Specific clinical indicators are not compulsory but they allow organisations to demonstrate performance. Data collected using the clinical indicators is reported into the EQuIP performance-indicator tool.

Clinical indicators allow comparisons from one year to the next and trends over time within an institution. They

also allow benchmarking with peers, but this comparative data must be taken in the context that submission of clinical indicators data to the national database is voluntary. In 2009 (the date of the last clinical indicators comparative report) participation was only around 50 per cent.

ACHS accredits more than 1400 healthcare organisations in Australia. It is not the only accrediting body but does the bulk of the work. Interestingly there is no database, government or otherwise, that gives the actual number of hospitals in Australia but ACHS believes it accredits 85 per cent of all acute-bed facilities.

Why do hospitals need accreditation? Hopefully it is because we want to provide safe and quality healthcare and do the best for our patients. In addition, private healthcare organisations need accreditation for funding and public hospitals need it for consumer trust.

On July 1 this year, the accreditation landscape changed with the implementation of 10 national safety and quality health service standards, issued by the Australian Commission on Safety and Quality in Health Care (ASCQHC).

The concept of national standards was recommended by the National Health and Hospital Reform Commission in 2009 with the primary aim to protect the public from harm and improve the quality of health service provision.

The Australian Commission of Safety and Quality in Health Care developed the 10 standards after extensive consultation with stakeholders. The difference between this model and that of ACHS is that the standards have not come from the industry (unlike the working party that generated the clinical indicators) but from the commission.

The national standards will become compulsory in January 2013 following a transition period.

These national standards will apply to all high-risk health services, which are defined as “health services that undertake invasive procedures into a body cavity or dissecting skin while using anaesthesia or sedation”. It is not clear where obstetrics fits into this definition.

The national standards are:

1. Governance for safety and quality in healthcare service organisations.
2. Partnering with consumers.
3. Preventing and controlling healthcare associated infections.
4. Medication safety.
5. Patient identification and procedure matching.
6. Clinical handover.
7. Blood and blood products.
8. Preventing and managing pressure injuries.
9. Recognising and responding to clinical deterioration in acute healthcare.
10. Preventing falls and harm from falls.

For detailed information go to the website: [www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/CA1C4B7F4C5B5547CA257793000528D5/\\$File/NSQHS%20Standards.PDF](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/CA1C4B7F4C5B5547CA257793000528D5/$File/NSQHS%20Standards.PDF).

ACHS has compared its EQuIP to national standards and found that 70 per cent of national standards content is covered by EQuIP but 80 per cent of EQuIP 5 is not covered by the national standards.

The difference is explained because the national standards focus primarily on clinical care issues. There is little on non-clinical management items.

(continued next page)

ACHS understandably is very threatened by the implementation of the national standards. While ACHS can act as an agent for accreditation of national standards, the thrust (and major source of income) is through selling its EQuIP accreditation product.

ACHS is trying to encourage healthcare organisations to maintain EQuIP accreditation in addition to national standards after 2013 by emphasising the strength and comprehensive nature of its accreditation but, as only the national standards will be required, this push is unlikely to be successful.

Victoria already has indicated that its public hospitals will use the national standards only. Ramsey Health Care likewise has said it will use national standards and Healthscope is yet to decide.

In this context the clinical indicators for formal accreditation will become redundant. Nevertheless they remain very useful tools to audit practice but exactly how anaesthesia accreditation will fit into this model is unclear.

Dr Margaret Cowling
Clinical Indicators Portfolio
Quality and Safety Committee

Safety alerts

Safety alerts may be general, equipment or drug related. All alerts are reviewed and edited by Fellows appointed by the Quality and Safety Committee.

IV Burette Safety Alert

Concerns have been raised regarding potential hazards associated with the use of burettes on IV lines where there is no valve on the burette to prevent air entering the line if the burette runs through to empty. This is a valid concern and clearly relates to hospital-wide management of IV infusions. Individual hospital policies have a range of approaches to improve safety in this regard. The ideal strategy is to run all limited volume IV infusions through a volumetric pump, and indeed many institutions are adopting use of such pumps for all IV infusions.

Fellows should consider requiring that IV burettes have either a valve to prevent air entrainment or be run using a volumetric pump.

ECRI Alerts

The ECRI Institute is a non-profit organisation that issues alerts from four sources: the ECRI International Problem Reporting System; product manufacturers; government agencies including the US Food and Drug Administration (FDA); and agencies in Australasia, Europe and the UK as well as reports from client hospitals.

Some alerts may only involve a single or small numbers of cases, there is no denominator to provide incidence and there is not always certainty about the regions where the equipment is supplied.

This section can only highlight some of the alerts that may be relevant. It is the responsibility of the hospitals to follow up with the manufacturer's representatives if they have not already been contacted.

Spacelabs-Patient monitors Equipped with Perioperative Option and start case/end case function: models

91367, 91369, 91370, 91387, 91393

Spacelabs states that the alarm on the above monitors may not be audible if the model is left in end case mode. However, visual alarms will continue to work normally.

Upgrade to the software is planned to improve the visibility of the audio alarm status.

Spacelabs Vital Signs Elance Patient Monitors: Model 93300

May stop working during use and fail to power on.

CareFusion-AVEA Ventilators Model Nos 17310, 17311, 17610, 17611, 17612

The above ventilators, over time, may issue a false high peak pressure alarm, open the safety valve and stop ventilating.

Phillips – NM3 Respiration Monitors and FloTrak Elite Modules

As a result of a defective manifold assembly affecting module flow performance in the above systems, there may be a display of incorrect tidal and minute volumes with the potential to lead to inadequate ventilation, particularly in pediatric patients ventilated at lower tidal volumes. The systems should be removed from service if the tidal and minute volumes displayed on the affected systems do not equate with volumes on the patient's ventilator.

Phillips IntelliVue Monitoring Products

Electromagnetic interference may cause some products to incorrectly display a flat ECG waveform, thus generating a false asystolic alarm. The problem originally occurred when bedside laptop computers were introduced, but Phillips suggests that other devices, such as electric motors or humidifiers, could also cause a problem.

Four of the IntelliVue monitoring modules may be affected: MMS model (3001A), MP2 (8102A) MP5 (8105A) and X2 (3002A).

If false alarms are occurring, contact Phillips to see whether a software upgrade will correct the problem.

Cardiac Science-Powerheart AED G3 Automatic External Defibrillators

A large number of reports have indicated that the device may incorrectly indicate that it is not “rescue ready” and the screen will show “service required”. Self tests have been designed to ensure the unit is functional when needed, and include monitoring battery charge, internal circuitry and the correct application of the pads, however there should be a daily check of the equipment to ensure that it is always “rescue ready”.

Medrad Continuum MR Infusion System Components

These components must remain secure in a MR environment.

These pumps are designed for use during magnetic resonance imaging and consist of an infusion pump and an IV stand with a mounting bracket. The infusion pump contains ferromagnetic materials, subject to magnetic attraction from the MR scanner. For this reason the system must be properly assembled with the pump and bracket securely fixed to the stand and the castors locked when in the MR room.

This alert follows report of an incident where the nurse removed the pump from the mounting bracket and the pump was forcefully pulled into the MR system’s bore.

Other such incidents have been reported although no patient injuries have resulted.

Terumo-Cardioplegia Monitors used with Model 8000 Sarns Modular Perfusion Systems

The monitor software may lose communication with the pump, resulting in a failure to track cardioplegia delivery volume. Terumo has received a number of such reports and states that the loss of communication occurs on system start-up but does not affect the actual cardioplegia delivery. There have been no reports of injury to patients as a result of this defect.

Central Vascular Access Catheters Hazards of Compression and Fracture

Health Canada has received several reports of catheter pinch-off in central vascular access catheters or implantable ports potentially leading to embolisation of the distal fragments to the pulmonary artery or the heart. The problem may occur as a result of mechanical compression between the clavicle and the first rib or excessive shoulder movement.

Early signs may be the inability to aspirate blood or chest pain or cardiac arrhythmias on injection. In such situations, early chest radiography is essential.

GE-Model B650 CARESCAPE Monitors

A number of problems have been reported:

1. The monitor may freeze during start-up or enter a continuous reboot cycle possibly during patient monitoring, thus preventing safe normal use.
2. If a monitor is connected to a USB port and the USB cable is disconnected the monitor may not alarm audibly and can only be corrected after the monitor has been restarted manually.
3. If the invasive pressure, SpO₂ or heart rate limits are adjusted from iCentral on the S5 network the alarm priority may change to the start-up level of the escalation.
4. Audible alarms may continue after alarm deactivation.

The local GE representative should be contacted for further action to correct the above problems (Ref GE 36070) if there is an affected product in your inventory.

Dr Patricia Mackay

Communication and Liaison Portfolio Manager

Quality and Safety Committee

Useful links

Anesthesia Patient Safety Foundation:

www.aspf.org

webAIRS:

www.anztadc.net

ANZCA website:

www.anzca.edu.au/quality-safety

Western Australia's foundation Fellows and the establishment of the Western Australian State Committee

The first annual business meeting of the Western Australian State Committee took place at the British Medical Association council room on June 9, 1956. Members of the committee could review the achievements of the past year with satisfaction. At this time the committee comprised two foundation Fellows of the Faculty of Anaesthetists, Drs Gilbert Troup and D R C (Bunny) Wilson, and Dr L G B (Graham) Cumpston, a foundation member of the Faculty who had been elevated to fellowship in January 1956.¹

The first honorary secretary's report of the WA State Committee included the following:

"In a country the size of ours it is impossible for the Board of Faculty to maintain satisfactory contact with Fellows and Members in the various states of the Commonwealth and the Dominion of New Zealand. The Board therefore exercised the powers given to it under additional Regulations (1955) and appointed State and Dominion Committees whose functions are to carry out duties delegated by the Board, to convene at least one scientific meeting each year and to advise the Board of any matters which may concern the interests of the Faculty.

"In July last year the Board appointed Drs G.R. Troup, Douglas Wilson and L.G.B. Cumpston to constitute the Western Australian State Committee. On 8th September 1955 this committee held its first meeting at which Dr Troup was appointed Chairman and Dr Cumpston Honorary Secretary. The committee has met on five subsequent occasions."²

The inaugural meeting lasted 30 minutes and took place at Dr Troup's rooms in Yorkshire House, 194 St



Georges Terrace, Perth. The first matter discussed was the Faculty scientific meeting. Were these meetings to be exclusively for Fellows and members, or did the committee have the right to invite the profession at large? The committee was keen to involve Fellows of the Faculty of Anaesthetists of the Royal College of Surgeons in England and sought advice from the board as to whether these professionals would first seek membership of the Australasian Faculty or would be entitled to fellowship outright.

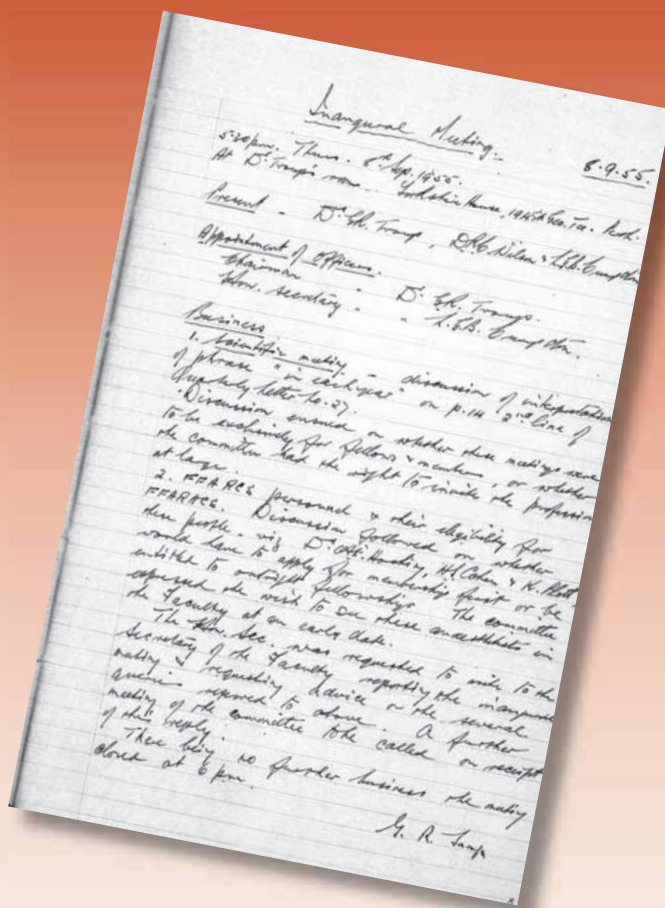
With only nine members and Fellows in WA there was insufficient time and resources to organise a scientific meeting during 1955 and it was suggested at the second committee meeting in October that March or April 1956 would be regarded as the earliest possible date. In fact the committee did not meet again until March 1, 1956, and at this time planning for the scientific meeting began in earnest. It was decided to hold the meeting on an evening in June at approximately the same time as the College (Royal Australasian College of Surgeons – RACS) scientific meeting. The meeting was to take the form of a symposium entitled "Controlled respiration in



anaesthesia and in medical conditions with respiratory embarrassment or paralysis" and anticipated the presentation of papers by an anaesthetist, a physiologist, a physician and a surgeon. Three more meetings of the WA committee were held before the annual scientific meeting on June 7, 1956.

The Faculty symposium commenced at 8pm and was now titled "The management of respiratory paralysis in anaesthesia and disease". The meeting opened with a short address by Dr L Souef, chair of the State Committee of RACS. Dr Douglas Wilson presented the subject from the anaesthetic aspect and Dr Beech, also a foundation Fellow of the Faculty of Anaesthetists, RACS, from the medical angle. Discussion was opened by Dr Thorburn (by invitation), from the physician's point of view, and Dr Peter Gibson discussed the thoracic surgical approach. The meeting closed at 10.30pm.

The honorary secretary's report of June 9, 1956, concluded with the following: "College Meeting – Perth – 1958. It is anticipated that the Annual Meeting of the College will take place here in 1958. This will undoubtedly include the Faculty and will be a function of great importance to us all."



The men who made it happen Dr Gilbert Troup

Gilbert Troup was one of the outstanding figures in anaesthesia practice in Australia. He led a rich career in medicine prior to his work during the early 1950s in helping to establish the Faculty of Anaesthetists, RACS.³

Born in Christchurch, New Zealand in 1896, he was educated in Melbourne and graduated in medicine from the University of Melbourne in 1922. He settled in Perth in the same year, working first at the Children's Hospital and then at the Perth Hospital, becoming a junior honorary physician in 1924 while maintaining a private practice in Subiaco.

A long and distinguished career in anaesthesia began when Dr Troup was appointed honorary anaesthetist to the Perth Hospital in 1927. He followed in the footsteps of William Nelson (who served from 1918 to 1926) and Bruce Burnside (served 1918 to 1923), who were the first honorary anaesthetists appointed to the hospital.

Dr Troup was a member of the Faculty's WA Committee from 1955 until 1959, serving twice as chair, from 1955 to October 1956, and from November 1957 until June 1959. He died in August 1962.

Dr D R C Wilson

D R C "Bunny" Wilson was perhaps best known for his contribution to paediatric and neonatal anaesthesia, particularly his pioneering work in WA.⁴

Born in 1906 in Perth, he graduated MBBS at Melbourne University in 1931. After a year as a resident medical officer at Perth Hospital he entered general practice in Dowerin, which continued until 1939. He served with distinction in World War II and was awarded an MBE, Military Division, for his service in Syria in 1941.

Dr Donald Stewart wrote in 2010 that it was Gilbert Troup who nurtured Bunny Wilson's interest in anaesthesia after the period of hostilities ended, and he soon became the first full-time anaesthetist in Western Australia, with posts at Royal Perth Hospital, Hollywood Repatriation Hospital and Princess Margaret Hospital, where he was director of anaesthesia from 1945 until 1956.⁵

Dr Wilson served on the WA Committee of the Faculty of Anaesthetists, RACS, from 1955 to 1966. He was chair twice, from November 1956 to September 1957 and from June 1960 to August 1961. He also served as Australian Society of Anaesthetists

(ASA) Executive Committee state representative for WA from 1947 to 1951. Dr Wilson died in January 1970.

Dr Ernest Beech

Ernest Beech was born in Adelaide in 1908 and studied medicine at the University of Adelaide, gaining his MBBS there in 1932. He relocated to Western Australia in 1933 to become a resident medical officer at Perth Hospital. Dr Beech was appointed medical registrar in 1934. He then spent two years in postgraduate studies in England at the Royal Chest Hospital and the Queen's Square Hospital.

Dr Beech obtained his MRCP in 1936 and, on his return to Perth, was appointed honorary outpatient physician and honorary anaesthetist to the Perth Hospital in 1938. He maintained this dual role until 1950, and was also in general practice until 1946. Dr Beech also served as anaesthetist to the neurosurgery unit at Perth Hospital. He contributed to postgraduate education in Western Australia as the secretary of the ASA Postgraduate Committee for two years.⁶

Above from left: Dr Gilbert Troup, Dr D R C Wilson, Dr Ernest Beech.

Western Australia's foundation Fellows and the establishment of the Western Australian State Committee

continued

Dr Beech joined the ASA in 1939 and later served in senior roles with that body which included a term as president from 1948 to 1949 and chair of the WA section from 1951 to 1953, and also as ASA Executive Committee state representative for WA from 1952 to 1953. Dr Beech retired from general medicine in 1966. He died in August 1976.

Fraser Faithfull, ANZCA Archivist with assistance from Professor Garry Phillips.

Footnotes:

1. Dr L G B (Graham) Cumpston, a foundation member of the Faculty of Anaesthetists, RACS, and the first secretary of the Western Australian Faculty Committee, became a Fellow of the Faculty in January 1956. It is likely that he deputised for Gilbert Troup on at least one occasion during the early negotiations for the establishment of the Faculty in 1950; refer Wilson, G, et al, One Grand Chain Volume 2, ANZCA Melbourne, 2004, page 179.

A very brief autobiography was included in his article, "Early Days of Anaesthesia at Royal Perth Hospital", in Harrison, R T [ed], Royal Perth Hospital Department of Anaesthesia Historical Notes, 1979, pp. 10-11.

2. Western Australian Committee minutes held in ANZCA Archives, Series 279.
3. For example see Cohen, H, "Gilbert Reynolds Troup" in Harrison, op cit, pp. 15-17; Kaye, Geoffrey, "As I Remember It 1927 - 1957", unpublished, p. 52. Copy held in ANZCA Archives, Series 155.

See also "Endotracheal Anaesthesia", educational film by G Troup, 1935, DVD copy held ANZCA Archives, Series 11, and Troup, G, E H Embley Memorial Lecture: "Some Current Anaesthetic Problems", The Medical Journal of Australia, November 27, 1954, page 841.

4. See Cohen, H, "Douglas Rose Campbell Wilson", in Harrison, op cit, p. 18. This paper formed part of the inaugural DRC Wilson Address (also known as the Bunny Wilson Lecture), ASA WA Section, March 1975; and also Cass, N, and Cooper, M, "Paediatric Anaesthesia in Australia: origins and developments", in Paediatric Anaesthesia 1996, 6: 69-78.

5. Stewart, D N, "Life's Highway: Lessons from People and Places", 2010 Bunny Wilson Lecture, copy held at ANZCA Archives, Series 11.

6. Refer Wilson, G, Fifty Years - the Australian Society of Anaesthetists 1934 - 1984, ASA, Edgecliff, NSW, pp. 163-165.

Further Reading:

Harrison, R T [ed], Royal Perth Hospital Department of Anaesthesia Historical Notes, 1979. This volume includes a number of historical articles relating to the period covered in this article. Copy held in ANZCA Archives, Series 152, file 947.

Wilson, G, Fifty Years - the Australian Society of Anaesthetists 1934 - 1984, ASA, Edgecliff, NSW.

Wilson, G, et al, One Grand Chain Volume 2, ANZCA Melbourne, 2004.

Successful candidates

Primary fellowship examination

August/September 2011

One hundred and sixty seven candidates successfully completed the primary fellowship examination and are listed below:

Elizabeth Hilke Kremer	ACT	Patrick Antony Mamo	NSW	Ali Jilani Ayoob Coowar	Vic
Akshat Sehgal	NSW	Philip Sidney McGrath	NSW	Angela Maree Marsiglio	Vic
Alyssa Joan Scurrah	NSW	Praveen Babu Mamillapalli	NSW	Audrey C-Yuen Bren	Vic
Amy Louisa Dickson	NSW	Robert Henk Crocket	NSW	Bernadette Jane White	Vic
Anna Hickson	NSW	Ryan Downey	NSW	Bethany Patricia White	Vic
Arjun Sido	NSW	Sean Robert Duncan	NSW	Catherine Laurien Pease	Vic
Ben Greenhalgh	NSW	Sebastian John Corlette	NSW	Craig Murray Ironfield	Vic
Benjamin Gareth Brown	NSW	Seema Kamaldev Saddi	NSW	Debra Weng Sze Leung	Vic
Benjamin Piper	NSW	Shanthi Widana – Pathirana	NSW	Emma Ruth Ford	Vic
Bruce Allen Seidel	NSW	Timothy David Robertson	NSW	Jacquelyn Peta Nash	Vic
Candice Peters	NSW	Torgeir Andre Westerlund	NSW	Jade Radnor	Vic
Chetan Reddy	NSW	Wei-Jie Zhuo	NSW	Jin Li	Vic
Claire Heather Stewart	NSW	Yee Ching Yeow	NSW	Joanne Darleena Samuel	Vic
Claire Louise Goldsbrough	NSW	Yin Yin Leow	NSW	Joanne Li Chien Ee	Vic
Clare Margaret Shiner	NSW	Yoon Leng Ooi	NSW	Larissa Douglas	Vic
Daniel Friedgut	NSW	Adam Philip Michael	Qld	Libia Estela Machado Munoz	Vic
Dennis Gokcay	NSW	Agustina Frankel	Qld	Maurice Peter Le Guen	Vic
Edward Kayesh Fairley	NSW	Andrew Douglas Wilke	Qld	Michael Conor Bulman	Vic
Elizabeth Ann Barber	NSW	Andrew James Jorgensen	Qld	Neil Andrew MacDonald	Vic
Hee-Sun Kim	NSW	David Goldsmith	Qld	Polly Spencer	Vic
Jacqueline McPhee	NSW	Heydon Kufakwame	Qld	Pungavi Kailainathan	Vic
Ji Young Ciel Heo	NSW	Jesse Gilson	Qld	Sarah Elizabeth Palermo	Vic
Jovan Brdaroski	NSW	Joanna Elizabeth Burton	Qld	Sarah Kate Magarey	Vic
Julie Martens-Nielsen	NSW	John Paul Cotter	Qld	Stephen Francis Watty	Vic
Karen Yee Ching Wong	NSW	Jonathan Hui Hwong Lau	Qld	Timothy Guy Coulson	Vic
Katherine Lanigan	NSW	Kenneth Chung Wah Lee	Qld	William Murray Ross	Vic
Khoi Nguyen Pham	NSW	Lenore Frances Van Der Merwe	Qld	Yoshiaki Uda	Vic
Louise Marie Sweet	NSW	Lisa May Lin Stanton	Qld	Zoe Wake	Vic
Margot Elizabeth Heaney	NSW	Matthew John Beech	Qld	Adam David Badenoch	SA
Mei Ying Camille Yip	NSW	Mihaela Viorica Petrila	Qld	Claudia Elsie Tom	SA
Monika Kenig	NSW	Mr. Tobias Paul Trink	Qld	Darrin Roderick McKay	SA
Naomi Pallas	NSW	Nathan John Peters	Qld	Fiona Joan Collingwood	SA
Neil Christopher Greensmith	NSW	Nigel Patrick Woodall	Qld	Hao-Zheng Wong	SA
		Patrick J. Glover	Qld	Joanna Louise Starkey	SA
		Poh Jee Hui	Qld	Khaschayer Saadat-Gilani	SA
		Rebecca Louise McBride	Qld	Martin John O'Reilly	SA
		Ryan Tsu-Kit Tan	Qld	Palash Kar	SA
		Saya Aziz	Qld	Preeti Anand Ananda Krishnan	SA
		Stephen Richard Daglish	Qld	Teoh Chee Yeow	SA
		Wayne Russell Shipton	Qld	Yasmin Kugler	SA

Successful candidates

continued

Ashley Alan Crosswell	Tas
Bibi Fatimah Shedleyah Dhuny	Tas
Anne Michelle Carlton	WA
Anthony John Klobas	WA
Cameron Paul Prosser	WA
Clare Victoria Frances Fellingham	WA
Duncan Bunning	WA
Melissa Amber Haque	WA
Scott Glen Douglas	WA
Wan Jun Song	WA
Cheng Wai Hui	HK
Hiu Kwan Ho	HK
Ip Kam Yuen	HK
Kai Chiu Lau	HK
Lam Ka Hing	HK
Lo Kar Yan Joyce	HK
Pak Wai Lau	HK
Tan Olivia	HK
Tang Suet Yee Rita	HK
Wing Kwan Lai	HK
Wong On Yat	HK
Ying Chee Lun Aaron	HK
Law Yen Shuang	Mal
Shahir Hamid Mohamed Akbar	Mal
Andrew John Colls	NZ
Chang Joon Kim	NZ
Christopher Aaron Hau Gwun Wong	NZ

David John Allen	NZ
Duane Elijah Anderson	NZ
Emma Jane Lloyd-Davies	NZ
Helen Agnes Lindsay	NZ
Helena Ruth Stone	NZ
Jane Jie Li	NZ
Jennifer Margaret Best	NZ
Julia Margaret Foley	NZ
Shaun Naidoo	NZ
Stuart Michael Millar	NZ
Julia Marina Singhal	NZ
Kerry Alexander Cressey Holmes	NZ
Kim Mary Phillips	NZ
Kushlin Rachel Higgie	NZ
Logan Gregory Marriott	NZ
Loretta Clare Muller	NZ
Luke Kain	NZ
Sarah Jane Phipps	NZ
Shaun Micheal Ryan	NZ
Thomas Alexander Knobloch	NZ
Yuan-Hsuan Chang	NZ
Chen Xinying	Sing
Loh Kent Neng Samuel	Sing
Priscilla Phoon Hui Yi	Sing
Tien Jong-Chie Claudia	Sing
Tiong Ing Hua	Sing
Xing Jieyin	Sing

Renton Prize

The Court of Examiners recommended that the Renton Prize for the half year ended December 31, 2011, be awarded to:

Wong On Yat	HK
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Merit certificates

Pharmacology

Chang Joon Kim	NZ
Lisa May Lin Stanton	Qld
Pungavi Kailainathan	Vic
Martin John O'Reilly	SA
Polly Spencer	Vic
Yoshiaki Uda	Vic
Adam David Badenoch	Qld
Nathan John Peters	Qld

Physiology

Pungavi Kailainathan	Vic
Debra Weng Sze Leung	Vic
Timothy Guy Coulson	Vic
Patrick J. Glover	Qld

Final fellowship examination

August/October 2011

Ninety-eight candidates successfully completed the final fellowship examination and are listed below:

Dilip Anand N.	ACT
Dinuk Arshana Jayamanne	ACT
Heman Tse	ACT
Amy Taylor	NSW
Brett Wells	NSW
Catherine Chwang	NSW
Frederick Luang Dart Lee	NSW
Gabrielle Louise Bullock	NSW
Jessica Natalie Smith	NSW
Keshavan Kanesalingam	NSW
Kirryn Amanda Lowe	NSW
Martin Yuk Chau	NSW
Maryam Hezar	NSW
Michael Bruce Alexander Kerr	NSW
Nadine Yamen	NSW
Neil Vanza	NSW
Paul Christopher Williams	NSW
Rebecca Jane Prentice	NSW
Rhys David Thomas	NSW
Samuel Cho	NSW
Siaw Ping Kho	NSW
Simon Phillip Spiers	NSW
Susmita Bhattacharya	NSW
Benjamin Charles Lincoln	Qld
Benjamin Peter Howes	Qld
Bryan Michael Cook	Qld
Carolyn Maree Wills	Qld
Conrad John Macrokanis	Qld
Daniel Martin Clarke	Qld
Aditya Kousik	Qld
Adrian Langley	Qld
Anna Maria Hallett	Qld
Anthony George Justus Lentz	Qld
Freya Emily Aaskov	Qld
George William Kennedy	Qld
James Edward Johnson	Qld
Jillian Katherine Streitberg	Qld
Koh Huey Ling	Qld
Lauren Joy Radford	Qld
Nicholas Peter Heard	Qld
Paul James Suter	Qld
Ryan George Savage	Qld
Stephen Graham Smith	Qld
Thomas George Matthiesson	Qld
Alison May Graham	Vic
Amardeep Singh Nanuan	Vic
Anthony Singh	Vic
Christopher Lawrence Kay	Vic
Clare Bronwyn McArthur	Vic
Emily Digiantomasso	Vic
Glen Warren Cook	Vic
Grace Priyani Gunasegaram	Vic
Ingrid Marion Funke	Vic
Kameel Yousif Marcus	Vic
Melinda Ann Chouman	Vic
Miles Christopher Charles Beeny	Vic
Nada Najib Shihab Alrawi	Vic
Paul Christopher Hales	Vic
Peter Redmond Shea	Vic
Pieter Strapelberg Peach	Vic
Raja Rengasamy	Vic
Stuart Lachlan Hastings	Vic
Andrew Beresford Foster	SA
Angela Mary White	SA
Donna Leanne Willmot	SA
Matthew Lee Geall	SA
Richard John Church	SA
Sarah Louise Preston Flint	SA
Sophie Jane Anderson	Tas
Anisa Aisha Binti Abu Baker	WA
Catherine Mary Vaughan	WA
Jakob Chakera	WA
Nicole Rani Khangure	WA
Peter Graham Unwin	WA
Rowan Marsh Drayton	WA
Sara Foroughi	WA
Thomas David Flett	WA
Yau Wing Sze	HK
Lau Shiu Kwan Candice	HK
Tang Pui Yan	HK
Tse Yee Wah	HK
Benjamin Vasantha Kumar	NZ
Colin Stewart Barnes	NZ
Daniel Alexander Hartwell	NZ
Daniel Mattathiah Levine	NZ
Elitza Vaneva Sardareva	NZ
Frances Cammack	NZ
Hendrik Stephanus Viljoen	NZ
Jethro Jason Dredge	NZ
Kurugalage Don Viraj Prasantha Siriwardana	NZ
Nicola Robyn Crowley	NZ
Peter John Robinson	NZ
Renee Louise Franklin	NZ
Ryan Jinu Jang	NZ
Sarah Lauren Sew Hoy	NZ
Sarah Preissler	NZ
See Hooi Geok	Sing
Vui Kian Ho	Sing

Cecil Gray Prize

The Court of Examiners recommended that the Cecil Gray Prize for the half year ended December 31 2011, be awarded to:

Stuart Lachlan Hastings	Vic
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Merit certificates

Merit certificates were awarded to:

Gabrielle Louise Bullock	NSW
Daniel Mattathiah Levine	NZ
Claire Bronwyn McArthur	Vic
Peter Shea	Vic
Nicole Rani Khangure	WA
Jakob Chakera	WA

Nine candidates successfully completed the International Medical Graduate Specialist Exam and are listed below:

Tracy Dawn Du Plooy	ACT
Stefan Jantschulev	NSW
Lokesh Anand	NT
Jonell Victor	Qld
Wilhelm Dreyer	Qld
Claudia Krellmann	Tas
Eric Daniel Nikolaus Knauf	Vic
Vaishali Londhe	Vic
Amit Lehavi	WA

New Zealand news



NZ declares anaesthesia ASM a great success

"Our NZ Anaesthesia Annual Scientific Meeting was fantastic," Dr Geoff Long, Chair of the New Zealand National Committee, said in expressing ANZCA's gratitude to the ASM organising committee from North Shore Hospital, led by Dr Michal Kluger.

In opening the annual scientific meeting, which was held in Auckland from November 2-5, Dr Kluger said event organisers aimed to stage an

ASM that was "challenging, educational and thought-provoking" and comments indicate they reached their goal.

"They did a brilliant job," Dr Long said. "There were excellent speakers, the organisation was superb and, above all, there was a great collegial atmosphere. The scientific program covered a range of interests very well. There was also plenty of humour including a wonderfully irreverent opening session cartoon, and great social occasions at which we could meet colleagues."

The ASM, which the ANZCA New Zealand National Committee hosts jointly with the NZ Society of Anaesthetists, attracted 298 participants who were

entertained and educated throughout the varied program.

At the opening, the 2010 New Zealander of the Year, Sir Ray Avery, inspired with the story of a "rags to riches" background, which saw him develop keen powers of observation. He said it was these that had often underpinned the inventions for which he is well known, including several in the medical field that benefit people in developing countries. Doctors, he said, should be taught the power of observation rather than relying solely on what patients said, which was often what they thought the doctor wanted to hear.

UK-born and raised Sir Ray paid particular tribute to the attitude of New Zealanders, whom he found inspiring after the restrictive mindset of post-war Britain.

"New Zealanders are not frightened of anything," he said. "For Kiwis, the impossible is the starting point. Everything I have been able to achieve has been because of that Kiwi ingenuity."

On the last day, well-known New Zealand psychologist Nigel Latta provided an entertaining but thought-provoking and politically incorrect guide on being a grown up.

In between were erudite clinical discussions, both in plenary sessions and popular workshops, and a fully-subscribed industry exhibition that provided plenty to look at during the breaks.

In his session on safety, Professor Alan Merry spoke about the World Federation of Societies of Anaesthesiology Lifebox Project, which aims to improve patient safety globally through a sustained change in practice.

He said that while the western world recognised pulse oximetry as essential, some 77,700 operating rooms worldwide lack this basic equipment; 31.5 million operations a year are performed without oximetry. For around \$US250, the Lifebox Project provides an affordable, quality pulse oximeter, an educational video and people to deliver and demonstrate it.

The message struck home with delegates at the conference dinner donating around \$NZ26,000 for the project. It was a fitting tribute to the interest and attitude of those attending, including the anaesthetic technicians whose conference ran in tandem with the ASM.

Opposite page clockwise from top left: Dr Geoff Long, Professor Kate Leslie, Dr Angela Enright, Dr Rob Carpenter and Dr Andrew Mulcahy; At the cocktail function, from left: NZ Trainee Committee Deputy Chair Dr Rachel Dempsey, Dr Paul Templer, Chris Hoefl, Tristan Tuhi and Chris Coombs; At the opening day cocktail function, from left: Dr Mary Faigan, Dr Michaela Hamschmidt and Dr Fiona Russell; Meeting up at the start of the ASM, from left: Drs Rachel Dempsey, Sarah Sew Hoy, Geoff Carden and Chris Jones; At the cocktail function, from left: Chief Medical Officer at New Zealand's Ministry of Health, Dr Don Mackie; President of the New Zealand Society of Anaesthetists, Dr Rob Carpenter; and Dr Andrew Love from North Shore Hospital; At pre-dinner drinks on the Friday night, from left: Dr Rachael van der Griend, Dr Ben van der Griend, Dr Terasa Bulger and Dr Nicola Broadbent.

Study documents severe aortic stenosis

Although most anaesthetists would recognise severe aortic stenosis as a major risk factor for perioperative complications in patients undergoing non-cardiac surgery, specific detail about this appears to be lacking, says an interdisciplinary research group at Nelson Hospital.

The research group, which has representation from anaesthesia, cardiology, nursing and echocardiography departments, has designed a user-friendly online database with the aim of prospectively collecting data on preoperative assessment, echocardiography data, anaesthetic techniques and perioperative complications for patients with severe aortic stenosis. This observational study has ethical approval from the NZ National Ethics Advisory Committee.

The group hopes to collect enough data to define more accurately factors relating to perioperative morbidity and mortality in patients with severe aortic stenosis undergoing non-cardiac surgery. It says that this should allow a standardised approach to the preoperative assessment of patients with aortic stenosis and improved information for patients regarding perioperative risk.

The group is seeking volunteers in New Zealand hospitals to join the research team and run the Aortic Stenosis Database (ASDB) project in their own departments by acting as local champions. Its plan is for every hospital involved to enter data on patients with severe aortic stenosis undergoing non-cardiac surgery. Each participating department will have access to its own data and the combined national results through the password protected online database.

Before starting the project, the group plans to invite all local champions to a one-day symposium in Nelson in March next year. The symposium will cover all aspects of the project and enable local champions to begin data collection when they return to their hospitals. There will be a nominal registration fee and attendees will be expected to cover travel and accommodation expenses.

Anaesthetists interested in getting involved with the ASDB project should contact Dr Joe Macintyre (Joe.Macintyre@nmhs.govt.nz) or Dr Matt Scott (Matthew.Scott@nmdhb.govt.nz) to reserve a place on the symposium and to register as a local champion for their department.



New Zealand National Committee meeting

ANZCA's new chief executive officer, Ms Linda Sorrell (above with Dr Geoff Long), attended the New Zealand National Committee (NZNC) meeting on November 25, giving the committee the opportunity to meet her and to discuss ANZCA's Strategic Plan for 2013-2015.

Items on the agenda included a discussion about conflicts of interest and sponsorship of CPD by pharmaceutical and medical equipment companies; ANZCA Curriculum Revision 2013; the NZNC budget; the provision of CPD activities for anaesthetists in smaller centres; clinical audit; and ANZCA's New Zealand Workforce Report. The CEO of the Health Quality and Safety Commission, Janice Wilson, was the guest speaker.

The workforce report has been approved by the ANZCA Council and will be released once the incoming government and cabinet have been settled following New Zealand's general election on November 26. The report looks at demand and supply scenarios for New Zealand's anaesthesia services for the period 2010-2030, basing its supply projections on ANZCA's 2009 New Zealand workforce survey and the demand picture on 2009 hospital usage data.

Medical council seeks feedback on regulating “special interests”

The Medical Council of New Zealand (MCNZ) is seeking feedback on how “special interests” within a “vocational scope of practice” should be regulated. “Special interests” refers to sub-specialty areas in which doctors should reasonably be expected to hold additional expertise beyond that needed to obtain vocational registration.

Until now, the MCNZ has taken a case-by-case approach in the way it has regulated special interests because it has seen different special interests presenting different levels of risk. However, it believes that special interests will become increasingly prevalent and that regulation should be clear, consistent and transparent. Consequently, it is proposing to introduce a framework to guide future decisions and policy development.

The council says that the framework mostly codifies what is already working well and will have minimal impact on the practice of most doctors, or on their continuing medical education. The framework is intended to encourage doctors to improve their skills, and not to impede innovation or to create barriers that prevent competent practitioners from working in their chosen field. The MCNZ has drafted a short consultation paper, available on www.mcnz.org.nz, with the closing date for comment being Monday, January 16.

NZ reduces supervision of UK-trained specialists

Following consultation, the Medical Council of New Zealand (MCNZ) has reduced from 12 to six months the supervision time required for UK-trained specialists who hold the relevant postgraduate qualification and specialist UK training certificate. The MCNZ will continue to review each application on a case-by-case basis with advice from the relevant college and may still require 12 months of supervision if the college recommends this. The change applies to new approvals from November 1 this year.

New guidelines for international medical graduates

The Medical Council of New Zealand (MCNZ) has published a handbook on its website (www.mcnz.org.nz) setting out the roles and responsibilities for international medical graduates coming to work in New Zealand, and for their employers and supervisors. It provides useful “best practice guidelines” on the orientation, induction and supervision of international medical graduates.

Trainee funding priorities

Health Workforce New Zealand (HWNZ) is reviewing its proposed prioritisation criteria for trainee funding following submissions from district health boards, education institutes and colleges, including ANZCA.

The first draft prioritised medical disciplines for funding based on vulnerability in the workforce (age of doctors, and dependence on international medical graduate specialists and general scoped doctors) and the contribution it considered each specialty was making to achieving five selected health targets.

ANZCA queried the methodology, especially that which gave anaesthesia a significantly lower priority than general surgery, despite the clear relationship between the two.

It is understood that HWNZ has now considerably revised the criteria in light of feedback. However, it has made it clear that it does not believe it should fund the “service” component of a trainee’s time in the hospital (that being the employer’s responsibility) and that it will give a higher priority to the more vulnerable disciplines.

Trainee survey seeks comment on College

New Zealand’s ANZCA trainees were encouraged to complete a recent NZ Medical Association’s Doctors-in-Training Council survey of vocational trainees to establish their satisfaction with the medical colleges. The survey closed on December 2. Information pertaining to ANZCA will be made available to the College in a collated, anonymous form and will provide valuable feedback on how trainees see ANZCA during their training.

Australian news

South Australia and Northern Territory



SA and NT registrars' meeting

On September 21, the South Australian and Northern Territory Continuing Medical Education Committee held the Registrars' Scientific Meeting. Three registrars, Dr Islam Elhalawani, Dr Andrew Foster and Dr Paul Lambert, presented their formal projects. Dr Foster received a prize for "Consent for anaesthesia in paediatric patients – an observational study".

International speaker at meeting

On November 2, the SA and NT Continuing Medical Education Committee held "Point-of-care diagnostics and goal-directed coagulation management algorithms" presented by international guest speaker Dr Klaus Goerlinger from Germany.

There were approximately 45 at the meeting with an additional eight participating via video conference from the Alice Springs and Royal Darwin hospital. The SA and NT section of the Australian Society of Anaesthetists held their annual general meeting prior to the meeting.

Clockwise from top left: Guest presenters Dr Andrew Foster, Dr Paul Lambert and Dr Islam Elhalawani; Dr Smrithi George, Dr Islam Elhalawani and Dr Allan Cyna; Dr Klaus Goerlinger; Formal Project Officer Dr Simon Jenkins with the prizewinner of the Registrars' Scientific Meeting, Dr Andrew Foster.

Western Australia



Bunker Bay paediatric anaesthesia meeting

The annual WA "Updates in Anaesthesia" meeting was held at Bunker Bay in Dunsborough, south of Perth, from November 4-6, 2011. The weekend began on Friday night with an enjoyable welcome barbeque and drinks for delegates, sponsors and their families which set the tone for a successful meeting.

Dr Mary Hegarty convened the meeting on behalf of the Department of Anaesthesia at Princess Margaret Hospital for Children. The theme of the meeting was "Paediatric Anaesthesia – It's Child's Play!" and included presentations that helped demystify the art of anaesthetising children; addressed common dilemmas in paediatric anaesthesia; and provided some of the latest in evidence-based anaesthetic practice.

The invited speaker was Dr Peter Platt, Deputy Head of the Department of Anaesthesia and Director of the Anaesthetic Adverse Drug Reaction Clinic at Sir Charles Gairdner Hospital. Dr Platt gave an excellent presentation on how to manage the child with an allergy.

Other speakers included Winthrop Professor Britta Regli von Ungern-Sternberg, the inaugural Chair in Paediatric Anaesthesia in Australia. Professor Regli von Ungern-Sternberg presented some of the data from a study where she was the lead author involving 9297 children receiving general anaesthesia at Princess Margaret Hospital. The study, which was published in *The Lancet*, showed a link between respiratory risk factors and respiratory adverse events before, during and after surgery in children.

Interstate visitors included Dr Ramanie Jayaweera and Dr Susan Hale from The Children's Hospital at Westmead, Sydney who were presenters in the workshop sessions.

On the Saturday evening delegates, sponsors and partners spent an enjoyable evening at Wise Winery dining, dancing and sampling some excellent wines.

Thank you to Dr Platt, sponsors, presenters and the Department of Anaesthesia at Princess Margaret Hospital, especially the convenor, Dr Mary Hegarty, who put together an interesting scientific program and an enjoyable weekend in the beautiful surrounds of Bunker Bay.

Above clockwise from top left: Dr Daniel Alexander leading an APLS workshop with delegates Dr Mark Williams, Dr Robin Colin and Dr Moira Westmore; Dr Charlotte Jorgensen presenting "The uncooperative child – ethical dilemmas" at the Sunday morning session; Dr Charlotte Jorgensen leading an APLS scenario with delegates; lunch in the marquee.

Victoria



Victorian Registrars' Scientific Meeting 2011

The Victorian Registrars' Scientific Meeting (VRSM) was held on Friday November 11 at the College and marked the 40th anniversary of these meetings.

The inaugural convenor, Dr Kester Brown, gave an entertaining introduction to the meeting and interestingly produced a handwritten abstract from one of the first presenters.

The program of two sessions and 10 presenters was chaired by Associate Professor Alicia Dennis and Dr Dean Dimovski.

The judges, Associate Professor David Story and Dr Elizabeth Hessian, awarded the VRSM 2011 Prize to Dr Stanley Tay for the best presentation on the day.

We would like to thank the judges, chairs, presenters and convenor for their time and participation which, in no small way, contributed to the success of our meeting.

Dr Andrew Buettner

Chair, Victorian Regional Committee

Above from top: Dr Kester Brown with VRSM 2011 Prize Winner Dr Stanley Tay; Dr Kirsten Bakyew, Dr Chuan-Whei Lee; Associate Professor Alicia Dennis; Convenor Dr Rick Horton; Guest Dr Kester Brown; Dr Rani Chahal; Dr Michael Kluger; Dr Stanley Tay; Judge Associate Professor David Story and Dr Dean Dimovski.

New South Wales



NSW hosts an ANZCA training accreditation workshop in Sydney

Twenty NSW Fellows attended the annual training accreditation workshop held by the Training Accreditation Committee (TAC) at the Sydney office on Saturday November 5.

The workshop trains anaesthetists in the requirements for reviewing the accreditation of hospital anaesthetic departments to ensure that anaesthetic departments meet College guidelines and are suitable to train ANZCA trainees.

The workshop included an overview of TAC processes, presented by the committee's chair, Dr Frank Moloney, and a "Mastering interview skills" workshop, presented by Dr Mark O'Brien, from the Cognitive Institute.

Workshops are held in a different location each year, depending on where the most inspections will take place. Alternatively, Fellows who wish to become inspectors may train by attending an inspection with senior inspectors.

Fellows who are interested in becoming an inspector may register by emailing Alan Penny, General Manager, Training and Assessments, at: apenny@anzca.edu.au.

Thanks to Drs O'Brien and Moloney for their interesting and informative presentations; and to Mr Warren O'Harae and Ms Annette Strauss for helping to organise the event.

NSW supervisors of training hold meeting and workshop

Nineteen enthusiastic supervisors of training joined the NSW regional educational officer in Sydney on November 10 for a half-day meeting and workshop.

Workplace-based assessments formed a large part of the meeting discussion and the focus for the workshop.

Using material lent to us by Dr Jodi Graham, the Western Australian regional education officer, we watched videotaped simulated clinical performances and practiced using a mini-CEX tool to rate them. The purposes of this tool as primarily formative, and the concept of a rating scale anchored in the required level of supervision for the trainee, were concepts we explored in detail.

The afternoon was entertaining and informative, and has helped the NSW supervisors of training on their journey to embracing the requirements of the new ANZCA curriculum.

Above from left: Dr Mark O'Brien of the Cognitive Institute, delivered a "Mastering interview skills" workshop; NSW SOT Workshop.

Tasmania

Tasmanian trainees put focus on professionalism

Tasmanian anaesthetic trainees were invited to an educational day in October, titled "The professional you". ANZCA and the Australian Society of Anaesthetists supported the day with additional sponsorship from Avant Medical Indemnity and Florrison Financial. We were also grateful to the heads of departments across the state for allowing trainees to attend, and the consultant anaesthetists left to manage their theatre lists by themselves!

The focus for the day was the professional side of anaesthesia. CanMeds provided the ideal framework to plan the day's program, as well as topics listed in modules 2 and 12 of the ANZCA curriculum. Those familiar with the curriculum will know how prominent the CanMeds framework is featured within our curriculum, and I expect that it will extend to the revised curriculum in 2013. The individual concepts in CanMeds, however, are not often discussed or taught, and our trainee education day changed that.

The morning started with "Anaesthesia non-technical skills" as the basis of a medical expert in anaesthesia. We then continued with a speaker for each facet of CanMeds: communicator, teacher, health advocate, manager and professional.

The astute will have noticed we appeared to miss "collaborator". Well, to truly appreciate collaboration, team-building exercises are clearly required. Tas Laser Skirmish in the hills outside of Hobart provided ample opportunity for us to practice our collaboration skills and we collaborated on beer and pizza afterward.

In all, it was a busy and really interesting day. Thanks to our speakers, everyone really enjoyed themselves, and learnt things in the process.

Shona Bright

Tasmanian ANZCA Trainee Committee Chair

Queensland



Queensland Regional Report

As the end of the year approaches, education and training support activities for 2011 are coming to an end. However preparation for 2012 is well under way with an emphasis on preparing for the revised curriculum to be implemented from 2013.

The newly appointed regional education officer convened a forum to discuss the revised curriculum for supervisors of training (SOTs). This meeting was facilitated by Drs Kate Hames and Brian Spain, local members of the Curriculum Redesign Steering Group, and Joanne Dwyer from the Curriculum Revision Project based in Melbourne. Presentations were given by Kate and Joanne about the key elements of the revised curriculum and the operational aspects of the new curriculum such as workplace-based assessments and the vision for the online training portfolio including logbook/volume of practice. This meeting provided an opportunity to share valuable information, discuss how SOTs and hospitals can be assisted with the transition process and how the revised curriculum may impact on rotational training placements, as well as highlighting concerns around some of the detail.

Queensland also hosted a fully subscribed Advanced Teachers Course on "Assessing trainees in practice, are you effective?" conducted by Maurice Hennessey, ANZCA Education Training and Development Manager.

Funding from the Queensland Health Ministerial Taskforce grant has been used to create four podcasts of primary exam preparation material. The first webinar addressing the "Demystifying Statistics" podcast was hosted on November 29. Subsequent webinars will be scheduled prior to the first sitting of the 2012 primary exam.

The Faculty of Pain Management (FPM) pre-exam course was convened for the first time in the Queensland office, demonstrating once again the versatility of the premises. The course attracted record numbers and will be hosted by the Queensland Regional Committee of the FPM again in 2012.

The College of Intensive Care Medicine hosted a well attended registrars' research day.

Again this year, retired anaesthetists have been invited to lunch at the Queensland office. While only small numbers attend this event it is greatly appreciated by these Fellows who are also frequent participants in continuing education activities.

All Queensland regional committees have conducted their last meetings for 2011 and have acknowledged the contribution of hard working members with off-site break-up dinners, providing the opportunity to reflect on the activities of 2011 and prepare to meet the needs of 2012.

The education and training calendar for 2011 has concluded.

The QRC would like to acknowledge the work of a dedicated and capable band of course convenors, lecturers and mock examiners who have offered trainees the following valuable learning opportunities:

- Primary lecture series – semester 1 and 2 (one Saturday a month for five months).
- Primary exam preparation course (two weeks of intensive exam preparation).
- Final exam preparation courses (two x one week of intensive exam preparation).
- Primary and final viva practice sessions (eight sessions throughout the year).
- Primary residential viva weekend.
- Podcasts and webinars funded from the Queensland Health Ministerial Taskforce grant.

Thanks is also extended to the members of the ANZCA/ASA Combined Continuing Medical Education Committee who hosted a well attended one day conference, three informative evening lectures and the annual registrars' scientific meeting.

Australian Capital Territory

CME workshop

The ACT Regional Committee held the continuing medical education workshop on November 12 entitled "Getting it going – cardiac support symposium".

Despite some technical issues, the day was a success with strong industry support and was well supported by local delegates. The day consisted of a short series of lectures followed by hands-on skill stations. The ACT Regional Committee thanks Dr Simon Robertson for convening the event and the speakers who gave presentations or provided guidance at the skill stations.

The next big event to be held in the ACT will be "The art of anaesthesia" on March 3-4 at the John Curtin School of Medical Research, ANU. The theme for this event, which is being convened by Professor Thomas Bruessel, will be "Outcomes – what really makes a difference?" There will be many local, interstate and international speakers providing interesting debate. Topics include nitrous oxide, intravenous fluids, supplemental oxygen, BIS monitoring, cricoid pressure and anti-inflammatories. Further information and registration forms will be available on the ACT website soon.

The committee congratulates Dr Geoff Speldewinde for his organisation of the Faculty of Pain Medicine Annual Scientific Meeting held in Canberra on October 28 and 29. The success of this meeting belies the fact that the position of director of chronic pain remains unfilled in our region. The meeting had a wide variety of speakers designed to appeal to a broad range of interests and was, by all accounts, very successful.

Finally, the ACT Regional Committee will hold its annual general meeting at 6pm on December 12 at the regional office. All ACT Fellows are cordially invited to attend. Please indicate your interest to Alison Inglis via email at act@anzca.edu.au for catering purposes.



Report on residential viva course

The Queensland Primary Viva Residential Course was held on August 27-28 at the Novotel Resort, Twin Waters. The course was aimed at providing intensive viva practice for trainees. The course was held over one-and-a-half days, one month before the ANZCA primary viva examination. The course was fully subscribed with the numbers capped at 20 participants.

Participants were paired and alternated through 14 viva stations over the weekend. We were fortunate to have involved Dr Patsy Tremayne, an educational psychologist, who witnessed the performance of all the candidates and was able to give valuable performance feedback.

All participants were very happy with the structure of the course, the quality of the vivas, and the facilities at the Novotel; this was reflected in the very positive feedback.

I would like to thank all the trial examiners: Drs Adam Suliman, Annabel Harrocks, Bernie Burke, Ewan Wright, George Pang, Helen Davies, James Craig, Nick Courtney, Richard Scolaro, Simon McPherson, Stephen Mitchell, Tanya Kelly and Willem Basson for all their time and effort in making this weekend a success.

Finally the efforts of the QRC in particular Sandra Shaw and Amity Evans, and the support of Michael Borrott from Abbott, made the weekend possible.

Dr Guy Godsall
Convenor

Opposite page from left: Dr Martin Culwick and Dr Genevieve Goulding at the CME evening lecture; Dr Ravikiran Sonawane.

Events

Navigating anaesthetic pitfalls in the goldfields



In early October, the inaugural Ballarat GP Anaesthetist Education Meeting was held at Novotel Forest Resort, Creswick with the theme "Navigating anaesthetic pitfalls in the goldfields".

The theme related to the very real risks faced by the early settlers with abandoned gold shafts throughout the area, and the clinical pitfalls awaiting the unsuspecting anaesthetist.

Although optimistically hoping for around 20 registrants, we were delighted with the final response of 47 delegates, with several GP anaesthetists (GPAs) from Bairnsdale even hiring a light aircraft to attend.

Dr Liz Bashford and Dr Jeyanthi Kunadhasan from Ballarat Base Hospital organised a stimulating day's meeting with talks by Ballarat anaesthetists and regional GPAs. The topics included "New modes of ventilation", the new European Fasting Guidelines, and the evolving guidelines for VTE prophylaxis with respect to the new anticoagulants.

Support from trade allowed for hands-on practice with video-laryngoscopy and ultrasound. The meeting provided a valuable forum for informal discussion between the anaesthetists predominantly from Western Victoria with some visitors from as far afield as Victor Harbour and Echuca.

There are plans to repeat this meeting on a regular basis for regional anaesthetists to complement the national meeting hosted by the ANZCA Rural SIG and the statewide Australian Society of Anaesthetists (ASA) country meeting organised by the ASA.

Above from left: William Fraser and Hock Tan; Dr Fred Rosewarne and Dr Michael Connellan (Photos courtesy of The Courier).

Above right clockwise from top left: Uluru; Dr John Archdeacon, Director of Anaesthesia at the Cairns Base Hospital received an ANZCA Council Citation at the meeting, which was presented by Dr Sean McManus; Dr Robert Lee, Professor Lorelei Lingard and Sue Burdeken; Dr Eileen Halliday and Dr Prani Shrivastava.

Patient safety – solid as a rock



The theme for the 2011 Combined Education, Management, Simulation and Welfare SIG meeting was "Patient safety – solid as a rock". The meeting was held at the Ayers Rock Resort from September 23-25.

Our speakers, known worldwide for their expertise in this subject, presented information on many facets of patient safety. This included education, communication, critical incident analysis, professionalism and ethical issues involving safe practice of anaesthesia and intensive care. Much of the information presented was new and challenged our prior understanding of what is a rapidly evolving field. These presentations led to considerable informal discussions between presenters and delegates during breaks. Full details can be obtained on the ANZCA and ACECC websites.

Similar to 2010, we continued the format of having corporate, non-medical speakers on the program. This again proved to be very popular with these workshops fully subscribed early in the registration period. This year we had "Minds at Work" who spoke about successfully bringing innovation and change to the workplace.

The social highlight of the meeting was the iconic "Sounds of silence" experience. Champagne was enjoyed while standing on a sand dune watching a beautiful sunset over Uluru, a didgeridoo playing in the background. This was followed by dinner, sitting under a spectacular canopy of the desert stars.

We look forward to seeing you for another interesting and exciting meeting at Sanctuary Cove in 2012!

Dr Rowan Molnar
Convener

The after-hours anaesthetist



In late October, 120 delegates decided to spring into action to attend the combined ACECC/ASA/ANZCA meeting in Orange entitled "The after-hours anaesthetist".

They were welcomed on a cool Friday evening with a delightful degustation dinner at the award-winning Lollie Redini Restaurant where good food, great wine and gracious company were enjoyed by all.

An entertaining and educational weekend followed, the program consisting of six sessions of lectures, group learnings, workshops and "the big debate". Numerous topics that might help the after-hours anaesthetist were presented, covering a variety of acronyms from O&G, CICO, BIS, NET, ABC, ECHO, EEG, US, TTE, NOF, HES, CHEST, Q&A to ALS!

The candle-lit conference dinner hosted by Michael Manners and Josie Chapman, and set amongst the vines of Orange Mountain Wines, was splendid. A special thank you to all the delegates who travelled far and wide to visit Orange, NSW at this magnificent time of the year. Thanks also for the wonderful work from Rhian, Warren, Annette and Tina from ANZCA's NSW office for co-ordinating this event.

Above clockwise from top left: Associate Professor Alicia Dennis; Orange Mountain Wines Dinner; Dr John Leyden's ultrasound workshop; Dr Steve Gibson and Dr Tim McCulloch; Dr David Wu workshop; NZ delegates.

CVP SIG at Hamilton Island



The Cardiothoracic, Vascular and Perfusion Special Interest Group (CVP SIG) biennial meeting was held at the Reef Hotel, Hamilton Island on October 2-5, 2011. The venue and the weather were outstanding and hugely popular amongst registrants.

The program for the meeting was drafted by the SIG executive over a one year period with many teleconferences to deal with issues arising during the organisation of the meeting. The hard work and attention to detail of the executive was evident at the meeting.

The keynote speaker was Professor Marco Ranucci from Milan, Italy. Professor Ranucci spoke on several topics including risk stratification and issues relating to blood transfusion in cardiac surgery. Other invited speakers included Dr Trevor Fayers (cardiothoracic surgeon) who discussed minimally invasive mitral valve surgery and Dr Tony Walton (cardiologist) who spoke on a range of invasive valvular procedures undertaken in the cardiology catheter laboratory. The guest speakers were extremely well received. Notwithstanding the contributions of the guest speakers the highlight of the meeting was the high quality and relevance of the many local speakers who were otherwise all CVP SIG members.

There were several notable and sometimes light-hearted sessions that drew particular attention. On day one Dr Mark "Moneybags" Buckland debated Dr Dean "Baywatch" Cowie on the topic "That the pulmonary artery catheter is a dead duck".

A poster prize session attracted seven entries: Professor Paul Myles and Professor Marco Ranucci judged Dr David Andrews' contribution, "Combining propofol and desflurane impairs desflurane-mediated myocardial preconditioning" to be the winner.

The optional afternoon session included interactive sessions relating to cardiothoracic anaesthesia Fellow training in Australia and New Zealand, 3-D echocardiography and cardiopulmonary bypass simulation.

The last day was devoted to echocardiography and included several difficult and important echocardiography challenges. This was followed by an echo quiz chaired by Dr Chris Bain and Dr Mark Buckland. The echo quiz was challenging and enjoyable and I thank Chris and Mark for their efforts.

The meeting was an outstanding success and I would also like to thank the delegates for their attendance, the speakers for their contributions and Ms Kirsty O'Connor from the College for her administrative assistance.

Dr David Daly
CVP SIG Chair

Above clockwise from top left: Hamilton Island at sunset; Delegates at the meeting; Professor Marco Ranucci; Professor Paul Myles, Dr David Daly and Dr Mark Shulman.



A potential audience of more than 1.5 million people in Australia and New Zealand have been exposed to issues relating to anaesthesia and pain medicine as a result of work by the communications team since September.

The launch of the Global Year Against Headache was a huge hit. Nearly 850,000 people were estimated to have heard or viewed Faculty of Pain Medicine (FPM) board member Dr Ray Garrick highlighting work being done by pain specialists to alleviate migraines and other headaches on Channel 10 news bulletins around Australia, as well as ABC NewsRadio, ABC Canberra and 2UE in Sydney.

The FPM's Spring Meeting also generated significant media interest, with a potential radio audience of 200,000 people hearing pain specialists talk about the causes and treatment for musculoskeletal pain. FPM Director of Professional Affairs, Associate Professor Milton Cohen, and South Australian

pain researcher, Professor Lorimer Moseley, appeared on 2UE in Sydney, 707 ABC in Sydney and 774 ABC in Melbourne to talk about aspects of pain, while the Royal Melbourne Hospital's head of pain services, Dr Malcolm Hogg, also appeared on 774 ABC Melbourne for a talkback session responding to callers' queries about pain-related issues.

The trial of Michael Jackson's doctor, Conrad Murray, provided an opportunity to talk about the use of propofol in anaesthesia. ANZCA President Professor Kate Leslie was interviewed by seven radio stations about the use and safety of propofol, as well as responding to the issue in two New Zealand radio news bulletins. The topic was also covered by the *New Zealand Herald*.

The NZ Anaesthesia Annual Scientific Meeting was covered by the *Sunday Star Times* and *Sunday News*, which reported on Professor Jamie Sleight's presentation about the genetic link in how patients respond to pain.

South Australian anaesthetist Dr Tony Burke and the Director of Medstar Emergency Medical Retrieval Service, Dr Dan Ellis, were interviewed by Adelaide 891 radio about the work of the MedSTAR emergency retrieval service, following Dr Burke's piece in the last *ANZCA Bulletin*.

And the Cardiothoracic, Vascular and Perfusion Special Interest Group meeting generated some media coverage, with Melbourne cardiologist Dr Tony Walton, interviewed by 2CC in Canberra about new surgical techniques that reduce the need for patients to undergo open-heart surgery for aortic and mitral heart valve replacements.

Meaghan Shaw
Media Manager, ANZCA

Media releases distributed by ANZCA (since September)

- “Causes of pain – physical or psychological” (October 27, 2011)
- “Pain specialists tackle \$1.2 billion a year migraine headache” (Australia – October 17, 2011)
- “Global Year Against Headache highlights costly migraine problem” (NZ – October 17, 2011)
- “New techniques reduce the risk of heart surgery” (October 3, 2011)
- “Michael Jackson court case – the use of propofol” (September 28, 2011)
- “ANZCA Bulletin out now: Windscreen repairs, Prolapse Down Under, diving paramedics” (September 26, 2011)
- “Patient safety the focus of anaesthetic conference” (September 22, 2011)

Since September, ANZCA has generated...

- 4 print stories
- 3 online stories
- 19 radio mentions
- 5 television stories

Dean's message



Spring crept up fast and another fantastic year has flown by. The FPM Spring Meeting in Canberra was a great success, with high delegate numbers. We did not resolve unanimously “yes” or “no” whether pain depended mostly on peripheral or central processes, but at the end of the debate I sensed a shift by many towards the importance of central factors. We owe a debt of thanks to Geoff Speldewinde, supported by our fantastic Faculty staff and ANZCA events office for putting on a great scientific program. This is not to overlook a great conference dinner amongst magnificent vintage aircraft such as G for George, and a Peter Jackson film, in the ANZAC Hall at the Australian War Memorial.

After the conclusion of the spring meeting in Canberra, Chris Hayes successfully brought together a group to finalise the agreed data set to be used for a national pain outcomes initiative. You will hear more of this in due course.

Our College and Faculty re-accreditation submission to the Australian Medical Council (AMC) is well underway, and occupying our staff and office bearers at what has turned out to be a very busy year end. For the Faculty staff this overlaps the examination at Brisbane, and follows hard on the spring meeting

and November board meeting so your understanding is sought if they seem heavily occupied – they are! We also have Ann Maree Bullard, an educationalist on a short term engagement, taking the blueprinting work forward in consultation with the board and education committee. This will be important for our AMC responses. Unfortunately the Medical Council of New Zealand second stage assessment for vocational recognition of pain medicine in NZ will not be complete by year end, but is still on track.

You should become aware that ANZCA Council passed a policy on bullying, discrimination and harassment for Fellows and trainees acting on behalf of the College or undertaking College functions. This applies equally to Faculty Fellows and trainees, and flows from Australian health and safety legislation which broadens the definition of a worker to include volunteers. The policy also sets out good advice and steps to be taken by those who could happen to be subjected to, or have to deal with, such unacceptable behaviours.

As this goes to press, there is another pain advocacy round about to commence – this time for chronic pelvic pain – referring specifically to the Australian population. A condition that has many taboos and misbeliefs, affects a very large group of sufferers (who are not all women, although most are), and for which there is a major need for better education, with understanding and application of the same biopsychosocial elements that apply to most other chronic pain. Who said chronic pain was mostly about motor vehicle and work accidents? By not being covered or dealt with under schemes such as

WorkCover, these patients appear to be even further away from adequate service provision than many other common pain conditions such as back pain or neck pain.

Pain medicine-related research projects continue to be well supported by the Anaesthesia and Pain Medicine Foundation. I have been struck again in the current round by their number, and given there is no specific allocation towards pain medicine, they have been awarded on their merit in an extremely competitive environment. With your soon-to-arrive subscription notice you will be asked to consider a donation to the Anaesthesia and Pain Medicine Foundation – please do consider this.

I would like to take this opportunity to thank on your behalf the hard working Board of the Faculty, its committees and our staff who support us. In addition I extend those thanks to the ANZCA Council, president, CEO and staff who all contribute to an organisation which we can be proud to belong to. It, combined with your “fellowship”, stands for quality where it counts – the advice and care we provide to our patients. I wish you all a safe and happy festive season, and a prosperous new year.

Dr David Jones
Dean
Faculty of Pain Medicine



Faculty of Pain Medicine 2011 examination

The 2011 Faculty of Pain Medicine examination was held from November 25-27 at the Royal Brisbane and Women's Hospital, Brisbane. The faculty was pleased to welcome Dr Kate Grady, FPM Royal College of Anaesthetists (UK), and Dr Donal Harney, FPM College of Anaesthetists of Ireland, as international observers. A record 28 candidates sat the exam. Twenty-three were successful. The Barbara Walker Prize for Excellence in the Pain Medicine Examination was awarded to Dr Roderick Grant (Qld). Merit awards went to Dr Simon Cohen (NSW), Dr Corry De Neef (Vic) and Dr Jason Yu (NSW).

Above clockwise from top left: Dr Meredith Craigie with Merit Award Winner Dr Simon Cohen; Dr Meredith Craigie with Merit Award Winner Dr James Yu; Dr Corry De Neef, Dr James Yu, Dr Meredith Craigie and Dr Simon Cohen; Dr Meredith Craigie (centre) with exam convenors Dr Paul Gray and Professor Julia Fleming; Merit Award Winner Dr Corry De Neef with Dr Meredith Craigie; Dr Meredith Craigie congratulates Barbara Walker Prize Winner, Dr Roderick Grant.

New admissions

By election:

Dr Paul Hardy, FRCA New Zealand
Mr Yun-Hom Yau, FRACS South Australia

2011 Pre-examination short course

The Faculty's pre-examination short course was held at the ANZCA Brisbane regional office on September 23-25. The course was attended by 30 pre-registered and registered trainees of the Faculty, our highest attendance yet. The trainees gave positive feedback and we thank the convenors, Drs Frank Thomas and Richard Pendleton, as well as Michelle Cordwell and the regional staff, for organising such a well-run event.

2012 Pre-exam short course

The 2012 pre-exam short course will be held from September 14-16, 2012, at ANZCA Brisbane Regional Office, West End Corporate Park, River Tower, 20 Pidgeon Close, West End Qld 4101.

FPM Fellows win 2012 ANZCA project grants and research awards

Our congratulations go to Dr Paul Wrigley who was awarded the St Jude Medical ANZCA Research Fellowship for his project "Neurophysiological assessment of residual thermnociceptive sensation following spinal cord injury – a pilot study", and to Dr Philip Finch who was awarded the Pfizer ANZCA Research Fellowship for his project "Investigating the adrenergic component of neuropathic pain".

Congratulations also go to Faculty Fellows Dr Michal Kluger, Professor Alan Merry and Professor Michael Paech who each were awarded 2012 project grants.

News

continued

2011 FPM Spring Meeting

The FPM Spring Meeting in Canberra from October 28-30 was a great success with more than 150 delegates and strong healthcare industry support.

The meeting commenced with an entertaining and energetic debate that provoked discussion amongst presenters and delegates.

FPM Director of Professional Affairs, Associate Professor Milton Cohen, and SA pain researcher, Professor Lorimer Moseley, appeared on 2UE in Sydney, 707 ABC in Sydney and 774 ABC in Melbourne to talk about aspects of pain as part of the event.

The international invited speaker from Denmark, Professor Lars Arendt-Nielsen presented on “Soft tissue pain – translating pain mechanisms from animals into humans” and “Mechanisms of movement-related pain, implications for physical rehabilitation”.

The meeting also featured many local speakers, with topics ranging from “Interventions in pain practice” to “The challenges of chronic widespread pain”.



Clockwise from top left: Dr David Jones, Dean of the Faculty of Pain Medicine at the conference dinner; Delegates at the meeting; The Australian War Memorial where the conference dinner was held; Dr Elnazeer Elfaki, Dr David Sommerfield and Dr Paul Gray; 2011 FPM Spring Meeting Convenor Dr Geoff Speldewinde and invited international speaker Professor Lars Arendt-Nielsen.

FPM Board meeting report

November 2011

Faculty Board

The Faculty of Pain Medicine Board welcomed Dr Kieran Davis to his first meeting as a co-opted North Island New Zealand representative, and observers, Dr Andrew Zacest and Ms Linda Sorrell, ANZCA CEO, who attended for the day.

Nomination forms for 2012 board election will soon be circulated for the six vacancies on the FPM Board. At least one of these vacancies must be filled by a Faculty Fellow with FANZCA, at least two by a Faculty Fellow with fellowship from a division, faculty or chapter of the Royal Australasian College of Physicians and at least one by a Faculty Fellow with FRACS. The remaining two vacancies may be filled by any Faculty Fellow. Nominations close on February 3.

FPM/Royal Australian College of General Practitioners online modular GP education in pain management

Development of this project is on schedule, expected for launch at the 2012 FPM Spring Meeting and GP12 Annual Scientific Meeting.

The Curriculum Development Committee has investigated opinions of general practitioners, specialists and interested parties to identify and prioritise a topic list for this collaboration. Initial support from the Bupa Foundation will lead to the launch of an Active Learning Module covering six one-hour topics, which will be delivered on the Royal Australian College of General Practitioners (RACGP) online education platform. The FPM Education Committee will approach experts in the topics to work with the RACGP on the pain medicine content.

Dr Morton Rawlin, RACGP Chair Victoria Faculty Representative and Chair of the National Faculty of Specific Interests, met with the FPM Board to discuss this initiative, other collaboration opportunities and improved liaison with GPs.

Australian and New Zealand Tripartite Anaesthetic Data Committee (ANZTADC)

At the suggestion of the ANZCA Quality and Safety Committee, the board supported reporting and including pain management-related complications and incidents, aimed at improving practice. The pathway for Fellows to notify such incidents will be investigated with ANZTADC and Fellows will be encouraged to submit data via WebAIRS, a web-based anaesthetic incident reporting system.

Liaison with pain societies

Discussion included activities of the Australian Pain Society Relationships and Communications Committee, on which the FPM has representation, developments in GP education in pain management, pain society collaboration in the National Pain Outcomes Initiative and the launch of the 2011-2012 Global Year Against Headache (GYAH). The need for advocacy to government, Royal Australian and New Zealand College of Obstetricians and Gynaecologists and the development of educational initiatives on pelvic pain was also raised.

The FPM Paediatric Pain Working Party will be amalgamated with the Australian Pain Society/New Zealand Pain Society Childhood Pain Special Interest Group, and a reporting mechanism to the FPM Board will be established.

Media releases that attracted interest on GYAH for Australia and New Zealand were co-ordinated by the ANZCA Communications Unit. Inclusion of the global year events of the International Association for the Study of Pain (IASP) in the Department of Health and Ageing calendar will be explored.

National Pain Strategy

The board supports Painaustralia in developing the National Pain Week in association with consumer groups and the Australian Pain Society. The key focus of the event will be consumers.

At an extraordinary general meeting of Painaustralia on October 20, amendments to the constitution of Painaustralia were considered and passed. Updates were provided on state initiatives, the meeting was addressed by the NSW Health Minister, and there were presentations from Queensland (Professor Julia Fleming), NSW (Dr Chris Hayes), WA Department of Health (Dr Andrew Briggs), Professor Michael Cousins and an update from the Painaustralia CEO, Ms Lesley Brydon.

Successful advocacy by Painaustralia will lead to revision of assessments for disability support pensions to ensure that people with chronic pain and a genuine need for support can qualify for the pension.

Victorian Regional Committee

The newly formed FPM Victorian Regional Committee will hold its inaugural continuing medical education event on December 14 at ANZCA House, the theme being "Central sensitisation – a medico-legal conundrum".

FPM Board meeting report continued

Fellowship

Mr Yun-Hom Yau, FRACS (SA) and Dr Paul Hardy, FRCA (NZ) were elected to Fellowship of the Faculty.

Scientific meetings

Dr Simon Tame, FANZCA, FPPMANZCA (NSW) was confirmed as a FPM nominee to the 2012 New Fellow's Conference.

Dr Gary Clothier was confirmed as the FPM 2015 Scientific Convenor.

National Pain Outcome Initiative

A face-to-face meeting in Canberra was successful in reaching provisional agreement on a minimum data set. A teleconference meeting will be convened to give an opportunity for those whose travel was disrupted by the Qantas grounding to have input. Funding opportunities will be explored under the Department of Health and Ageing Chronic Disease Prevention and Service Improvement Fund as a matter of urgency.

Professional

Medicare Telehealth Advisory Group

Two draft papers for consultation have issued: Telehealth Technical Standards Position paper and Guidance on Security, Privacy and Technical Specification for Clinicians. On November 14, the department advertised an invitation to apply for funding for Telehealth support.

Pharmaceutical Benefits Advisory Committee (PBAC)

Subsequent to the Faculty's May submission regarding PBS-subsidised opioids, we are advised of this being referred to the National Medicines Policy Committee, and that no changes were to be made to the PBS arrangements for the time being. The Faculty has indicated to the National Medicines Policy Committee its willingness to be further involved.

Increased rate of prescribing is not the only concern, but an increased mortality emerging as a public health issue. The board considered its role in bringing this to the attention of relevant authorities and the development of strategies to deal with it.

Terms of reference

In a project encompassing all of ANZCA, terms of reference are being finalised for all Faculty committees and sub-committees. The Faculty also has representation on an ANZCA working group developing terms of reference for Fellows and trainees occupying leadership roles within ANZCA and the FPM.

Library update

New titles

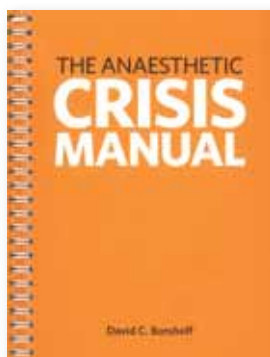
Books can be requested via the ANZCA Library catalogue www.anzca.edu.au/resources/library/book-catalogue.html.

ANZCA members may borrow up to five books at a time from the ANZCA Library. Loans are for three weeks and can be renewed on request. Members may also reserve items that are out on loan.

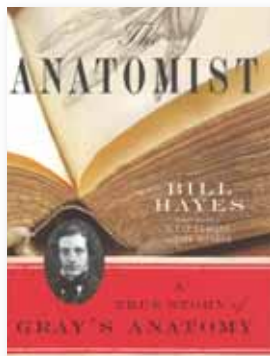
Items will be sent to other library users, however Melbourne-based members are welcome to visit the ANZCA Library to collect their books. When requesting an item from the catalogue, please remember to include your name, ID number and postal address to ensure prompt delivery.

Cardiac anesthesia and transesophageal echocardiography / Wasnick, John D. [ed]. -- 1st ed -- New York: McGraw-Hill Medical, 2011. Online Textbook via *AccessAnesthesiology*

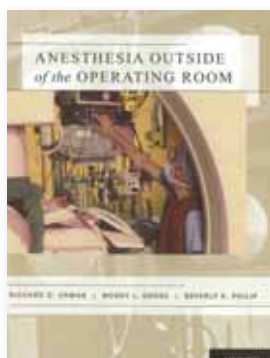
Current procedures : surgery / Minter, Rebecca M.; Doherty, Gerard M. -- New York: McGraw-Hill Medical, 2010. Online Textbook via *AccessAnesthesiology*



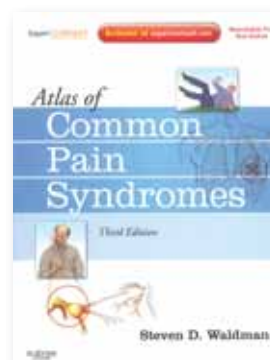
The Anaesthetic crisis manual / Borshoff, David C. -- Cambridge: Cambridge University Press, 2011.



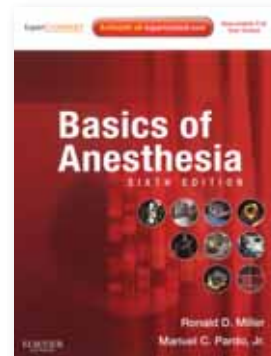
The Anatomist: a true story of Gray's Anatomy / Hayes, Bill. -- New York: Ballantine Books, 2008. Kindly donated by Dr John Russell



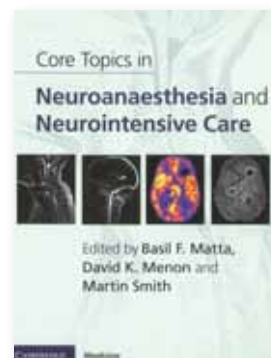
Anesthesia outside of the operating room / Urman, Richard D. [ed]; Gross, Wendy L. [ed]; Philip, Beverly K. [ed]. -- Oxford: Oxford University Press, 2011.



Atlas of common pain syndromes / Waldman, Steven D. -- 3rd ed -- Philadelphia, Pennsylvania: Elsevier Saunders, 2012.



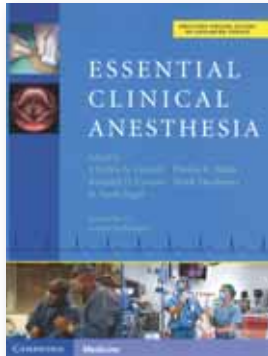
Basics of anesthesia / Miller, Ronald D [ed]; Pardo, Manuel C Jnr [ed]. -- 6th ed -- Philadelphia, PA: Elsevier Saunders, 2011.



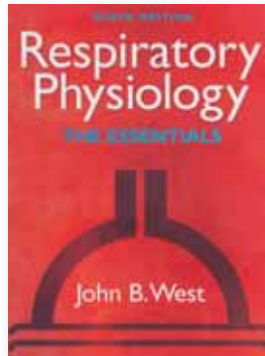
Core topics in neuroanaesthesia and neurointensive care / Matta, Basil F. [ed]; Menon, David K. [ed]; Smith, Martin [ed]. -- Cambridge: Cambridge University Press, 2011.



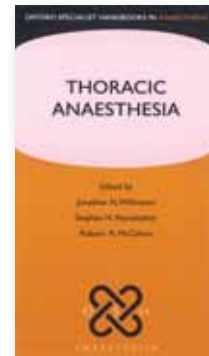
Dr Podcast scripts for the final FRCA / Leslie, Rebecca A. [ed]; Johnson, Emily K. [ed]; Thomas, Gary [ed]; Goodwin, Alexander P.L. [ed]. -- Cambridge: Cambridge University Press, 2011.



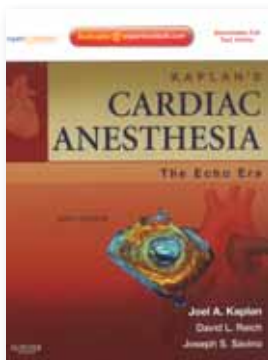
Essential clinical anesthesia / Vacanti, Charles A [ed]; Sikka, Pankaj K [ed]; Urman, Richard D [ed]; Dershwitz, Mark [ed]; Segal, B Scott [ed]. -- Cambridge: Cambridge University Press, 2011.



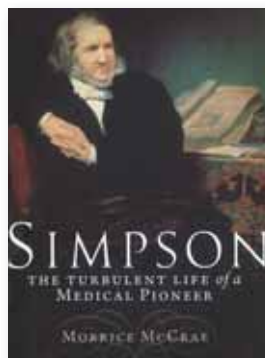
Respiratory physiology: the essentials / West, John B. -- 9th ed -- Philadelphia: Wolters Kluwer/Lippincott Williams and Wilkins, 2012.



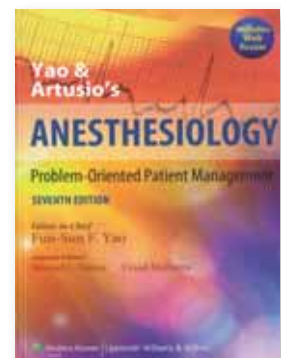
Thoracic anaesthesia / Wilkinson, Jonathan N. [ed]; Pennefather, Stephen H. [ed]; McCahon, Robert A. [ed]. -- Oxford: Oxford University Press, 2011.



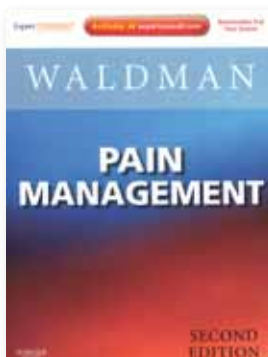
Kaplan's cardiac anesthesia: the echo era / Kaplan, Joel A [ed]; Reich, David L [ed]; Savino, Joseph S [ed]. -- 6th ed -- Philadelphia: Elsevier-Saunders, 2011.



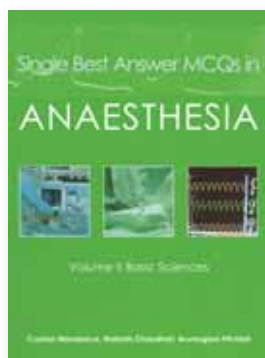
Simpson: the turbulent life of a medical pioneer / McCrae, Morrice. -- Edinburgh: John Donald, 2010. Kindly donated by Dr John Russell



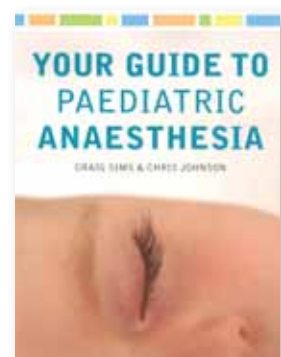
Yao and Artusio's anesthesiology: problem-oriented patient management / Yao, Fun-Sun F [ed]; Fontes, Manuel L [ed]; Malhotra, Vinod [ed]. -- 7th ed -- Philadelphia, PA: Wolters Kluwer/Lippincott Williams and Wilkins, 2012.



Pain Management / Waldman, Steven D. [ed]. -- 2nd ed -- Philadelphia, PA: Elsevier Saunders, 2011.



Single best answer MCQs in anaesthesia: Volume II basic sciences / Mendonca, Cyprian; Chaudhari, Mahesh; Pitchiah, Arumugam. -- 1st ed -- Shrewsbury, UK: tfm Publishing Limited, 2011.



Your guide to paediatric anaesthesia / Sims, Craig; Johnson, Chris. -- Sydney: McGraw-Hill Companies, 2011.

Library highlights

The ANZCA Library is on hand to assist with information queries from all Fellows, trainees and IMGS members throughout Australia and New Zealand. Recent queries include:

- Obstetric emergency drills.
- Real-time opioid prescribing.
- Indigenous Australians and communication in health.
- Pain medicine competencies.
- How to review a research paper.
- Tips and tools on keeping current.
- Cultural and gender experiences of pain.

Pain research highlights

Single dose oral analgesics for acute postoperative pain in adults. Moore RA, Derry S, McQuay HJ, Wiffen PJ. Cochrane Database of Systematic Reviews. 2011, Issue 9. Art. No.:CD008659.

Drug therapy for treating post-dural puncture headache. Basurto Ona X, Martínez García L, Solà I, Bonfill Cosp X. Cochrane Database of Systematic Reviews. 2011 Issue 8. Art No.:CD007887.

Perioperative single dose systemic dexamethasone for postoperative pain: a meta-analysis of randomized controlled trials. De Oliveira GS Jr, Almeida MD, Benzon HT, McCarthy RJ. Anesthesiology. 2011;115(3):575-88.

Pain responsiveness to opioids: Central versus peripheral neuropathic pain. Smith HS, Meek PD. Journal of Opioid Management. 2011;7(5):391-400

Efficacy of small doses of ketamine with morphine to decrease procedural pain responses during open wound care. Arroyo-Novoa CM, et al. Clinical Journal of Pain. 2011;27(7):561-6.

Multidisciplinary Pain Programs for Chronic Noncancer Pain. Jeffery MM, Butler M, Stark A, Kane RL. Technical Brief No. 8. AHRQ Publication No. 11-EHC064-EF. Rockville, MD: Agency for Healthcare Research and Quality. September 2011. www.effectivehealthcare.ahrq.gov/ehc/products/212/760/TechBrief8_PainProgramsCancer_20110930.pdf

Analgesics for Osteoarthritis: An Update of the 2006 Comparative Effectiveness Review. Chou R, McDonagh MS, Nakamoto E, Griffin J. Comparative Effectiveness Review No. 38. AHRQ Publication No. 11(12)-EHC076-EF. Rockville, MD: Agency for Healthcare Research and Quality. October 2011. www.effectivehealthcare.ahrq.gov/reports/final.cfm.

Technology and tools research highlights

Critical incident reports concerning anaesthetic equipment: analysis of the UK National Reporting and Learning System (NRLS) data from 2006–2008. Cassidy CJ, Smith A, Arnot-Smith J. Anaesthesia. 2011;66(10):879–88.

The effects of short interactive animation video information on preanesthetic anxiety, knowledge, and interview time: a randomized controlled trial. Kakinuma A, et al. Anesthesia and Analgesia. 2011;112(6):1314-8.

Performance of the pediatric-sized i-gel compared with the Ambu AuraOnce laryngeal mask in anesthetized and ventilated children. Theiler LG, et al. Anesthesiology, 2011;115(1):102-10.

Clinical factors associated with the non-utilization of an anaesthesia incident reporting system. Haller G, Courvoisier DS, Anderson H, Myles PS. British Journal of Anaesthesia, 2011;107(2): 171-79.

Information technology applied to anaesthesiology. Kheterpal S, Tremper KK. Philadelphia: Saunders, 2011. Anesthesiology Clinics 29(3). Including an article entitled 'The Use of Computers for Perioperative Simulation in Anesthesia, Critical Care, and Pain Medicine' by Lambden S and Martin B.

Medical technology in Australia: key facts and figures. Medical Technology Association of Australia (MTAA), 2011. www.mtaa.org.au/pages/images/MTAA%20Factbook.pdf

Contact the ANZCA Library

Librarian: Laura Foley
Web: www.anzca.edu.au/resources/library
Phone: +61 3 8517 5305
Fax: +61 3 8517 5381
Email: library@anzca.edu.au

ANZCA Council meeting report

November 2011

Report following the council meeting of the Australian and New Zealand College of Anaesthetists held on November 19, 2011

Death of Fellows and trainees

Council noted with regret the death of the following Fellows:

- Dr Iain MacDonald (NZ) FANZCA 1992, FFARACS 1981
- Professor Lucien E. Morris (USA) FANZCA 1992, FFARACS 1989

College honours and awards

- Dr Leona Wilson and Dr David Chamley have been appointed life members of the New Zealand Society of Anaesthetists.
- The Dr Ray Hader Trainee Award for Compassion for 2011 was awarded to Dr Katherine Jeffrey (NSW) for her contribution to the welfare of junior doctors and students.

Education and Training Committee and trainees

Transition arrangements for existing trainees and the revised curriculum

Council approved a plan for existing trainees to transition into the revised curriculum from the start of the 2013 hospital employment year (HEY). Details will be communicated to trainees and Fellows in due course, including confirmation of trainees' completed training time and elements of training prior to the end of the 2012 HEY to confirm the stage of training that they will transition into for the revised curriculum.

Curriculum revision project – revised governance structure

Council approved the Curriculum Implementation Planning Group (CIPG) to ensure co-ordination and alignment of decisions and activities to create a seamless transition from the current training program to the revised training program.

New policy model for the ANZCA training program

Council approved a new policy model to support the revised curriculum. This will comprise the regulations and a training handbook. The information will be presented logically and with a high level of clarity to ensure accessibility for all those needing to access information about training.

Primary Exam Subcommittee and Final Exam Subcommittee

Council approved the following as members of the Primary Examination Subcommittee for 2012: Associate Professor Ross MacPherson (Chair), Dr Andrew Gardner (Deputy Chair), Dr Patrick Farrell (Chair of Examinations), Dr Meredith Craigie (Chair, Faculty of Pain Medicine Examinations Committee), Dr Mark Reeves (council representative), Dr Peter Doran, Associate Professor David Story, Dr Graham Roper, Dr Emma Giles, Dr Stephen Barratt and College of Intensive Care Medicine (CICM) ex-officio representative (TBA).

Council approved the following as members of the Final Examination Subcommittee for 2012: Dr Vida Viliunas (Chair), Dr Mark Buckland (Deputy Chair), Dr Patrick Farrell (Chair of Examinations), Dr Mark Priestley, Dr Chris Cokis, Dr Lynne Rainey, Dr Damian Castanelli, Dr David Tremewen, Associate Professor Jennifer Weller, Dr Sally Wharton, Dr Kerry Gunn, Dr Chris Butler (co-opted member), Dr Roman Kluger (co-opted member) and Dr Meredith Craigie (co-opted member).

Trainee Committee membership

Council approved the membership of the ANZCA trainee committees in New Zealand and each Australian region.

ANZCA Training Agreement

Council approved a revised ANZCA Training Agreement. Trainees will be required to agree to the terms and conditions of the agreement when paying their annual training fee.

Finance

Council approved the ANZCA budget for 2012 and the 2012 Schedule of Fees. The key elements of the 2012 budget reflect the heavy investment in the College's future (in particular the curriculum), a broadening of the scope of the College activities and a continuation of the commitment to engagement with the fellowship.

Fellowship affairs

New Fellows Conference

Associate Professor David Scott has been appointed the Councillor in Residence for the New Fellows Conference – Yallingup, Western Australia (May 9-11, 2012).

Professor Alan Merry has been appointed the Councillor in Residence for the New Fellows Conference – Mornington Peninsula, Victoria (May 1-3, 2013).

Annual scientific meetings

Dr Michelle Mulligan has been selected as the Councillor to the Regional Organising Committee for the 2014 ASM (Sydney from May 2-7, 2014).

Dr Rodney Mitchell has been selected as the Councillor to the Regional Organising Committee for the 2015 ASM (Adelaide from May 6-11, 2015).

Council approved that the 2018 ASM will take place in Darwin, NT, from May 4 to 9, 2018.

ANZCA ASM Officer

Council acknowledged the significant contributions made by Dr Nicole Phillips in her role as the ANZCA ASM Officer for a number of successful annual scientific meetings. Dr Vanessa Beavis (NZ) has been appointed to the role of ANZCA ASM Officer.

Internal affairs

Continuing professional development standards

Council approved a continuing professional development standard for specialist anaesthetists and specialist pain medicine physicians. The standard will be published on the ANZCA website.

ANZCA policies

Council has approved the following policies:

- Internet, email and computer usage policy.
- ANZCA intellectual property (IP) policy, version 2 (to broaden guidance on sharing of material with external organisations).
- ANZCA policy on bullying, discrimination and harassment for Fellows and trainees acting on behalf of the College or undertaking College functions.

Reference to the latter will be added to all existing terms of reference for committees, subcommittees and working groups. Copies of these policies will be available on the ANZCA website shortly.

2013-2015 ANZCA strategic plan

The current ANZCA 2010-2012 strategy plan is due for a review. Council approved the formation of the ANZCA Strategic Plan Project Group to develop a project plan which:

- Clearly sets out ANZCA's vision for the future.
- Identifies and works with internal and external influences.
- Is fully integrated with operational and financial planning and processes.
- Makes best use of the collective skills, expertise and resources of the College council, committees, Fellows, trainees and staff to improve the safety and quality of anaesthesia services.
- Is developed in a collaborative manner and is owned collectively by council, Fellows, staff and trainees.

ANZCA terms of reference (TOR) project

National/regional committees: TORs have been developed for the Australian regional committees and the New Zealand National Committee. Feedback and comments were received from all the regional and national committees, with additional input from the Executive Committee and councillors.

Examination Committee TORs:

Following consultation with relevant Fellows, TORs were approved for the Examinations Committee (version 2), the Final Examination Subcommittee (version 1) and the Primary Examination Subcommittee (version 1).

ANZCA regulations

Regulation 3 – “Regional and national committees of the College”:

Following consultation with regional and national committees, this regulation has been amended to improve clarity and to take into account the TOR developed for these committees.

Regulation 14.6 – “Application to present for examination”:

Currently regulation 14.6.5 states that the closing date of the exam shall be 56 days before the written section. To ensure sufficient time to deal with growing numbers of examination applications, the regulation has been amended so that the closing date is “a minimum of 56 days” before the written exam.

Professional documents

PS37 Statement on Local Anaesthesia and Allied Health Practitioners:

This professional document and accompanying background paper have been approved by council and will be circulated to regional/national committees, FPM, ANZCA Trainee Committee and relevant special interest groups for comment.

To2 Guidelines on Checking Anaesthesia Delivery Systems:

This professional document and

accompanying background paper have been approved by council and will be circulated to regional/national committees, FPM, ANZCA Trainee Committee and relevant special interest groups for comment.

To4 Guidelines on Equipment to Manage a Difficult Airway During Anaesthesia:

This professional document and the accompanying background paper have been approved by council.

Professor Kate Leslie
President

Dr Lindy Roberts
Vice President

ANZCA Council meeting report continued

October 2011

Report following the council meeting of the Australian and New Zealand College of Anaesthetists held on October 8, 2011

Education and training

Panel of Examiners: The following appointments have been made to the Final Exam Panel of Examiners for 2012: Dr Prani Shrivastava; Dr Jonathon Hopkinson; Dr Gregory Steele; Dr Mohua Jain; Dr Fiona Johnson; Dr Jonathon Rothwell and Dr Sudharshan Karalapillai.

Retention of ITA forms: Council agreed that in-training assessment (ITA) documents would be retained for a period of seven years following admission to fellowship, as these may be required for Fellows to work overseas. This is similar to the approach taken by universities and in line with privacy legislation. The ANZCA Privacy Policy will be updated to reflect this change.

Fellowship affairs

2015 Adelaide ASM: The convenor and scientific convenor for the 2015 Annual Scientific Meeting to be held in Adelaide will be:

Convenor: Dr Aileen Craig

Scientific Convenor:
Dr William (Bill) Wilson

New Fellows Conference report:

Council welcomed a presentation by Dr Emily Wilcox about the 2011 New Fellows' Conference "Managing the change" held in Hong Kong in conjunction with the combined scientific meeting.

Internal affairs

Terms of reference template: The following clauses are to be added to the ANZCA terms of reference template and all existing terms of reference for committees, subcommittees and working groups:

"The discussions of each ANZCA committee, subcommittee and working group are confidential to its members."

"Conflicts of interest will be managed in accordance with the ANZCA conflict of interest policy."

ANZCA/FPM roles terms of reference:

New occupational, health and safety laws that will take effect in early 2012 will explicitly extend the responsibility of businesses to their volunteer workforces and require volunteers to contribute to a safe and healthy workplace. To assist the many Fellows and trainees who contribute to ANZCA in a voluntary capacity, terms of reference are to be developed for those occupying leadership roles within ANZCA and FPM. These will include clarifying the role and its responsibilities, the support that will be provided as well as lines of reporting. Council has approved the formation of a Roles TOR Working Group, comprising Dr Michelle Mulligan (Chair), Dr Mark Reeves, two FPM representatives (to be announced) and Dr Lindy Roberts. This group will consult with those in leadership roles in the process of developing role descriptions for them.

Community representation: Council approved the revision of the Community Representation Policy to more clearly define the process for the recruitment of additional community representatives. For further information about this policy, please contact Rebecca Conning, Policy Officer on + 61 3 8517 5333.

2012 ANZCA Training Scholarship:

Council awarded the 2012 Training Scholarship to Dr Tjung Wai Wong from Malaysia.

Knowledge resources review:

Following consultation with the board of FPM, regional/national committees, the ANZCA Trainee Committee and the honorary curators, Council approved a History and Heritage Strategy subject to consideration of the implementation plan and the financial analysis.

Professional documents

PS37 Statement on Local Anaesthesia and Allied Health Practitioners:

A document development group to review PS37 will comprise Professor Kate Leslie (lead), Professor Barry Baker, Dr Kerry Brandis and Dr Peter Roessler.

PS38 Statement Relating to the Relief of Pain and Suffering and End of Life Decision:

A document development group to review PS38 will comprise Associate Professor Milton Cohen (lead), Dr Roger Goucke, Professor Alan Merry and Dr Peter Roessler.

Professional document on the expert witness:

A document development group to develop a professional document and accompanying background paper that defines the College's policy on the expert witness will comprise John Biviano (lead), Dr Andrew Buettner, Dr Peter Roessler, Dr Michael Skinner, and Dr Leona Wilson.

Workforce

New Zealand Anaesthesia Workforce Survey Report:

Council has given its support to this report and approved its publication in its entirety. The report will be launched in the near future. Council approved the New Zealand Medical Association consensus statement "The Role of the Doctor in the 21st Century".

Research

2012 project grants and research awards:

Professor Leslie, Professor Merry and Associate Professor Scott did not participate in the decision making about these awards. The following grants and awards were approved by Council (see opposite):

Researchers	Project	Funding Requested	Funding Recommended
Professor Paul Myles	ENIGMA-II trial long term follow-up study	\$60,000	\$60,000
Professor Mike Paech	Methylnaltrexone to prevent intrathecal morphine-induced pruritus after caesarean delivery: a randomised clinical trial (The MEAN ITCH Trial)	\$40,273	\$40,273
Dr Neil Pollock	Malignant hyperthermia: exome sequencing for gene discovery	\$59,680	\$59,680
DrBrendan Silbert	Long term anaesthesia cognition evaluation (LOTACE) study	\$60,000	\$60,000
Professor Alan Merry	Development of a behaviourally anchored rating scale to assess use of the WHO surgical checklist: the WHO's BARS Study	\$57,745	\$47,000
Dr Tomas Corcoran	The influence of inspired oxygen concentration on oxidative stress, resolution of inflammation and lymphocyte subsets in human sub-lethal reperfusion injury	\$58,536	\$48,000
Professor Matthew Tak Vai Chan	The optimal timing of preoperative smoking cessation	\$59,950	\$43,000
Dr Justin Skowno	Tissue perfusion monitoring in paediatric liver transplantation using near infrared spectroscopy	\$58,420	\$41,000
Dr Ian Seppelt	An exploratory study of perceived risks, benefits and barriers to the use of selective decontamination of the digestive tract in Australasian ICUs (SuDDICU)	\$59,846	\$42,000
Dr Paul Wrigley	Neurophysiological assessment of residual thermnociceptive sensation following spinal cord injury-a pilot study	\$56,114	\$28,000
Dr Philip Finch	Investigating the adrenergic component of neuropathic pain	\$59,672	\$30,000
Dr Megan Allen	"Light" versus "deep" sedation for elective outpatient colonoscopy: recall, procedural conditions and recovery	\$38,840	\$19,000
Dr Michael Kluger	Predictors of persistent postsurgical pain following total knee joint arthroplasty	\$35,248	\$18,000
Professor Paul Myles	Recovery and well-being after major surgery: complications, functional recovery and the measurement of disability-free survival	\$60,000	\$30,000

Following discussion, the following applications were approved by council for funding of the second and third years of these projects, pending Research Committee review of satisfactory progress reports.

Researchers	Project	Funding Requested	Funding Recommended for 2012, 2013, 2014
Professor Paul Myles	ENIGMA-II trial long term follow-up study	\$60,000	\$60,000
Dr Neil Pollock	Malignant hyperthermia: exome sequencing for gene discovery	\$59,680	\$59,680 (year 1) \$57,500 (year 2) \$44,000 (year 3)

ANZCA Council meeting report continued

Second year funding from 2011

The following was approved by council for funding of the second year of this project following receipt of a satisfactory progress report.

Applicant	Project Title	Requested for 2011	Funding Recommended for 2011, 2012 and 2013
Dr David J Canty	Investigating the applications of anaesthetist-performed transthoracic echocardiography in non-cardiac anaesthesia	\$80,000	\$60,000 (years 1 and 2) \$20,000 (year 3 – scholarship only)

Third-year funding from 2010

The following was approved by council for funding of the third year of this project following receipt of a satisfactory progress report.

Applicant	Project Title	Requested for 2010	Funding Recommended for 2011 and 2012
Dr Michael J Barrington	The Australian and New Zealand Registry of Regional Anaesthesia (AURORA Study)	\$76,954	\$70,000

The **Harry Daly Research Award** was awarded to **Dr Neil Pollock** for his project “Malignant hyperthermia: exome sequencing for gene discovery”.

The **Mundipharma ANZCA Research Fellowship** was awarded to **Professor Paul Myles** for his project “ENIGMA-II trial long term follow-up study”.

The **Pfizer ANZCA Research Fellowship** was awarded to **Dr Philip Finch** for his project “Investigating the adrenergic component of neuropathic pain”.

The **St Jude Medical ANZCA Research Fellowship** was awarded to **Dr Paul Wrigley** for his project “Neurophysiological assessment of residual thermnociceptive sensation following spinal cord injury - a pilot study”.

2012 Academic Enhancement Award: Council approved the 2012 Academic Enhancement Grant to be awarded to **Professor Colin Royse** for his project “Cognitive decline following anaesthesia and surgery – is inflammation the cause?” in the amount of \$90,000.

2012 Simulation/Education Grant:

Applicant	Project Title	Funding Requested	Funding Recommended
Dr Daniel Mullany	Disposition of sedative, analgesic and antibiotic drugs during simulated extracorporeal membrane oxygenation	\$35,000	\$35,000

2012 Novice Investigator Research Grant:

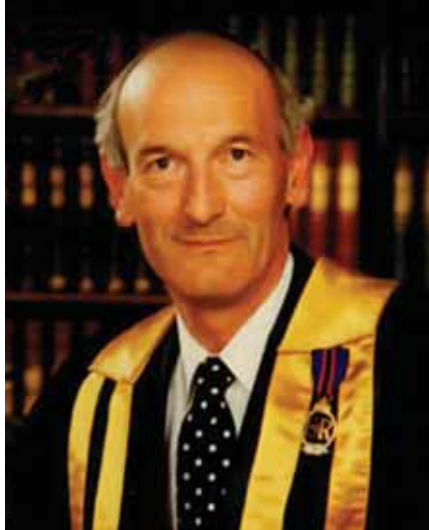
Name	Project	Funding Requested	Funding Recommended
Dr Elsa Taylor	The paediatric pharmacokinetics and pharmacodynamics parecoxib	\$20,000	\$8000
Dr Andrew Lansdown	Hyaluronidase and peripheral nerve blockade – influence on onset time, extent of block and plasma local anaesthetic levels	\$12,215	\$12,215

Professor Kate Leslie
President

Dr Lindy Roberts
Vice President

Dr David Cranleigh Thomson Bush

1926 – 2011



Dr David Bush died in Christchurch on July 5 aged 84.

David was born in Wellington and grew up on a farm in the Awatere Valley, an isolated area in the upper South Island (now known for being part of the Marlborough wine region), and as a boy always wanted to be a farmer. However, his father had other ambitions for him and sent him to secondary school at Christ's College in Christchurch where he was a prefect and gained his school colours for shooting. He also did well enough academically to obtain a place at the University of Otago in Dunedin and then on to its medical school, graduating with his MBChB in 1952.

Following graduation, David completed his house surgeon years at Christchurch Hospital and then took the six-week boat trip to England as the ship's doctor. In the UK, he continued anaesthesia training, obtaining the DA while working in Whittington Hospital.

Dr Bush returned to Christchurch to finish his anaesthesia training and, having obtained his FFARACS, he took up a post as a consultant anaesthetist. At this time he also met, and after a three-week courtship proposed to, his wonderful wife Nan.

David's initial interests included paediatric anaesthesia and he anaesthetised a lot of children with great skill in his early career.

He eventually dropped some sessions at Christchurch Hospital and developed a busy private practice. His surgeons recall him as being meticulous

in his work – a great attribute for an anaesthetist – and caring to his patients. He was also willing to come in at all hours for emergencies.

David was very highly regarded by the nursing staff at all the hospitals in which he worked. He was forever the polite gentleman, always calling the nurses "Sister", never by their first names, and was known for his impeccable manners. He was also much liked for his habit of calling into the wards at the end of a busy day in theatre to check that all was well and offer to reinsert any IVs.

Although quite conservative by nature, David did have an innovative side. When the Inland Revenue Department decreed that only vans could be claimed as work vehicles, he took the back seats out of his racy yellow Mitsubishi and turned it into a van! Early on in his private career he recognised that the backless theatre stools, which were the only seating provided in theatre at that time, were not good for the anaesthetist's posture during long cases. To solve this problem, he installed the "Bush Chair of Anaesthesia" in the theatre he used most. This was a padded swivel chair with arms, which made extended plastic surgery cases a lot more comfortable. On the clinical side, the PACU nurses recall that he was one of the first Christchurch anaesthetists to prescribe IV rather than IM analgesia for his patients in the recovery unit. This was unusual at the time.

Another of David's contributions to anaesthesia in Christchurch was the encouragement of younger anaesthetists starting out in private practice. He was a great mentor and even arranged with his surgeons to hand over some of his lists to help them get started. He would also very generously put on a luncheon at his local restaurant for our annual meeting.

Away from the operating theatre, David had a wide range of interests. Encouraged by his school friend, radiologist Shailor Weston, he joined the Royal Naval Reserve where he served as a medical officer for more than 15 years, reaching the rank of Surgeon Lieutenant Commander and receiving the Volunteer Reserve Decoration for his work.

His interest in things nautical extended to his owning various boats that were used for family holidays on the Southern Lakes where he also

headed for winter skiing. He was a keen golfer and bridge player as well as a model train enthusiast – using leftover orthopaedic plaster-of-paris for his scenery.

Along with his hobbies and busy work schedule, David, in conjunction with his colleague, the late Dr Bill Pryor (the author's father), somehow managed to co-author the third and fourth editions of Bill's book, *A Manual of Anaesthetic Techniques*. These were published in the late 1960s and early 1970s and, being a very practical tome, proved popular with the junior anaesthetic staff at that time. The fourth edition even managed a Spanish translation! David also contributed the chapter "Anaesthesia for Major Oral Surgery" in Bill's other book on anaesthesia for dentistry.

David retired in his early 60s, determined to leave anaesthesia practice while still "on top of his game". This he certainly achieved. He had several years of happy retirement with Nan, who had not only looked after the family during David's very busy career but had also been his secretary, making herself constantly available to answer the phone to surgeons and patients. There were no practice rooms or mobile phones in those times. He was devastated when Nan was diagnosed with motor neurone disease and his health deteriorated rapidly after she died.

However, even in the rest home, afflicted with the symptoms of Alzheimer's disease, David's impeccable manners remained. He continued to greet family and friends, whom he no longer recognised, with a wonderful smile and ever-polite greeting. Unfortunately, his good manners caused occasional problems. When David was moving around the home, Zimmer frame pile-ups were a common problem with David always insisting that the ladies went through the doorways first!

David will always be remembered as a very principled man, a true gentleman, a skilled anaesthetist who gave great care to a huge number of patients and great service to his surgeons, a very generous colleague and a very devoted husband, father and grandfather, who is greatly missed.

Dr Peter Pryor, FANZCA, Christchurch